University of Alberta

Thoughts on Teen Sex: Adolescent Perceptions

by

Alison Kelly Barnfather ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment
of the requirements for the degree of Master of Science

Centre for Health Promotion Studies

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled **Thoughts on Teen Sex: Adolescent Perceptions** submitted by Alison Kelly Barnfather in partial fulfillment of the requirements for the degree of Master of Science.

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Dedication

I would like to dedicate this work to my family in appreciation of the constant support and encouragement they have offered through all of my endeavours.

Abstract

An exploratory descriptive design was chosen to address adolescent sexual activity and sexual risk behaviour. Ten at-risk teenagers were interviewed on their perceptions of sexual behaviour and sexual risk. The participants described their family backgrounds as characterized by dysfunction and instability. As well, many of these teens had been in and out of school and had frequent interactions with social service agencies.

These young adults showed a strong knowledge of current sexual health issues but illuminated a number of weak areas in the process of transforming knowledge into behavioural practice. The adolescents' environment, sexual health education, risk experimentation and previous sexual experiences play dominant roles in the sexual decision making of teens today. Adolescents were given the opportunity to describe their views of first and subsequent sexual experiences, pregnancy, STDs, HIV/AIDS, emotional costs, contraceptives as well as parental, friend and media influences on sexual activity.

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First I would like to thank the young adults who willingly spent time talking to me about their unique experiences. These teens demonstrated exceptional insight and shared a wealth of information. As I spent weeks secluded in my office in the basement, I felt the presence of twelve others at my side at all times. I would also like to acknowledge Derek Chewka for his assistance in recruiting participants for this study.

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CHAPTER 1

INTRODUCTION

> The young . . . are full of passion which excludes fear; and of hope which inspires confidence. (Aristotle, Rhetoric Book II)

Today, increasing numbers of adolescents are engaging in sexual behaviors, often without protecting themselves from the consequences of sexual activity. Knowledge of pregnancy prevention, transmission and prevention of disease do not translate into risk-reduction behaviors. Why? Current research has suggested that adolescents are at increased risk for human immunodeficiency virus (HIV) infection, sexually transmitted diseases (STDs), and pregnancy because they engage in a set of high-risk behaviors (Hoppe, Wells, Wilsdon, Gillmore, & Morrison, 1994). These behaviors may include factors related to the young age of first sexual experience, multiple sex partners, and infrequent and unplanned sexual encounters (Herold, 1994). Studies also showed that a positive mindset towards safer sex practices can influence sexual behaviors, yet 75% of adolescents who intend to use protection fail to do so (Beazley, 1992). Underlying factors influencing this decision may include a lack of social support from parents, friends, partners, church groups, and teachers (Ramsum, Merion & Mathias, 1993). Media messages and the promotion of roles of adolescents on television and the movies can also influence teens (Dolan, Corber & Zacour, 1990). In addition, alcohol and drug use can interfere with the most sincere intentions (Svenson & Varnhagen, 1990). Furthermore, Beazley wrote that there are three essential parts to developing a behavioral strategy. This recipe for success includes (a) information, (b) skills, and (c) motivation. In order to attempt to understand why a gap between knowledge and behavior exists and how to achieve the right combination of the above ingredients, we need to find the answers from the adolescents themselves.

Haffner (1998) explained that becoming a sexually healthy adult is a key developmental task of adolescence. Achieving sexual health requires the integration of psychological, physical, societal, cultural, educational, economic, and spiritual factors. Sexual health encompasses sexual development and reproductive health including such characteristics as the ability to develop and maintain meaningful interpersonal relationships; appreciate one's own body; interact with both genders in respectful and appropriate ways; and express affection, love, and intimacy in ways consistent with one's own values. In light of the content of most sex education classes, it appears that we can learn more about preparing adolescents to tackle issues of sexuality. The "Just say no" approach to adolescent sexual activity is based on the belief that the only healthy avenue for teen sex drive is complete abstinence from all sexual behaviors until marriage (Haffner, 1998). We know that HIV/AIDS rates are rising among 13- to 19-year-olds, teen pregnancy rates remain significantly high, and the prevalence of STDs among adolescents places them at the greatest risk of all age groups.

In Canada, until very recently, limited research has been done on sexuality in general, and some of this work has focused on adolescent sexual behaviour and risk taking. Most of the research focused on adolescent sexual health has been conducted within the last 5 to 10 years. What sexuality means to adolescents, how it relates to other aspects of teenage life, and what strategies teens use to manage or incorporate it into their lives has not been studied in any detail (Brooks-Gunn & Furstenberg, 1989). In particular, topics such as frequency of behaviors other than intercourse, pubertal education, relation of sexual behaviors to other adolescent behaviors, and the influence of social contexts (schools and community) are lacking in published research. There is a continuing need for both quantitative and qualitative studies to understand how young people learn about their sexuality, how it is influenced by their environment, and the meaning of sexuality and sexual relationships in their lives (Haffner, 1998).

Health promotion needs to go beyond focusing on the technical aspects of contraception to adopt a more holistic perspective of adolescent sexual behaviour (Herold, 1994). The bias in health research has been to focus on quantitative designs, as evidenced by numerous surveys. These assessments of adolescents' level of knowledge regarding STD/HIV prevention and safer sex techniques show that there is a gap between acquired sex education and reported sexual behavior. Although teen responses to surveys focused on disease transmission and prevention are knowledgeable, there has not been a corresponding decline in risky sexual behaviour nor a reduced incidence of negative consequences. An "understanding of youth thinking about [sex] requires qualitative methodology that allows the generation of novel ideas rather than limiting answers to a fixed set of choices"(Hoppe et al., 1994, p. 118). Historically, the questions asked in the survey studies "were not based on the insiders' (the adolescents') emic perspectives but were the outsiders' (the researchers') etic formulations" (Strunin, 1991, p. 227). According to Strunin, an ethnographic study of risk behavior would provide an examination of the context of behavior: an examination of the facets of adolescent behavior as part of a larger socio-cultural system. Adolescence is a time when young people develop the knowledge, attitudes, and skills that potentially become the foundation for psychologically healthy adulthood.

> The need to address adolescent health behavior has been documented extensively, particularly as health habits that are established during the teenage years often expose youth to premature health risks, and develop into habits that are difficult to change during the adult years. (Levin & Coronel, 1997, p. 17)

Those of us involved in adolescent health research must strive to uncover how all factors interplay to influence teen decision-making with regards to sexuality.

Purpose of Study

Despite HIV/AIDS, STDs, and pregnancy being increasingly potential threats to the adolescent community, heightened attention needs to be directed to answering the question of why adolescents engage in risky sexual behaviors. A literature review has failed to provide evidence that the situation has been adequately explored from the perspective of the adolescents themselves and in light of their developing sexuality. The purpose of this study is to describe the underlying issues and concerns of today's youth regarding their sexual behaviours and their risk of the negative outcomes of sexual activity.

Research Question

This research seeks to probe how adolescent perceptions of sexual activity impact on sexual risk taking and sexual health. In order to understand the context of adolescent sexual behaviors and eventually build upon the information, skills, and motivation needed for successful behavior change, the guiding question for this study was, "What are adolescent's perceptions of the key elements of sexual behaviour and sexual risk?" Sub-questions included: How does previous sexual experience impact on sexual activity? What are adolescent impressions of sexual health education? How do adolescents define risk behaviour and how do these behaviours impact their lives?

CHAPTER II

LITERATURE REVIEW

There are differences in opinion regarding the extent of literature review that should be conducted prior to a qualitative research study (Morse & Field, 1995). The most extreme method is to go blindly into the data-gathering process without influence from the existing literature. In this study, a manual and electronic literature review was conducted both prior to the initiation of data collection and following data analysis. Books, journal articles, and government documents were examined to develop a background for this study. This literature review presents what is currently known about teen pregnancy, sexually transmitted diseases, and HIV/AIDS transmission in order to illuminate the need for studying adolescent sexual behaviours. The background statistical data were identified and subsequently written before the interviewing process began. In order to let the topics of sexual behaviour and sexual risk most important to the adolescents emerge from the interviews the adolescent sexuality and risk sections of the review were left unfinished until after data collection and analysis had been completed. In retrospect, this researcher recommends that a base of knowledge on all facets of the research can only help to understand the themes emerging from the data. In the future the entire literature review would be completed prior to data collection.

Exploration of the literature begins with a review of the published documents dealing with adolescence as a period of development, with special attention to sexuality and sexual behaviors. Next, the issues of risk behavior and the indicators of an "at-risk" population with regards to sexual activity are discussed. The topics of HIV/AIDS, STDs, and pregnancy are presented, with a focus on the statistical findings, associated antecedents, and consequences.

Adolescent Sexuality

Adolescence is Latin, meaning the state or process of growing up. There are many proposed definitions of the exact age of adolescence, but no definitive answer was found in the published literature. Karen Hein, the President for the Society of Adolescent Medicine, referred to adolescence as the time between 13 and 21 years of age. The Centre for Disease Control in Atlanta, Georgia, claimed that 13- to 19-year-olds are in adolescence. The World Health Organization declared the term *youth* to mean those between the ages of 15 and 24 years. Although the end of childhood is marked by the beginning of puberty, the conclusion to the period of adolescence is ambiguous at best. Today's concern over teenage sexuality is couched in political and economic terms, as evidenced by discussions of the societal and individual costs of AIDS, STDs, and teen pregnancy (Brooks-Gunn & Furstenberg, 1989; Committee on Adolescence, 1995; Spingarn & DuRant, 1996). It is of great importance, however, to delve into the inner dimensions of teen sexuality to enrich our understanding of what it is that discourages the negative consequences and encourages well-informed decision-making and safer sex practices (Moore & Rosenthal, 1992).

The interest in and experimentation with sexual behaviors has increased in adolescents as generations have passed. In the 1950s petting was the most common intimate teenage sexual experience, adolescents reached physical maturity later and married earlier, and teenage intercourse was uncommon except among the oldest and engaged or married adolescents (Haffner, 1998). The revolutionary period of the 1960s and 1970s challenged traditional values in almost all areas of life, and these values were replaced by values emphasizing individual freedoms and personal growth (Harold, 1986). Harold discovered this quotation: "At age 15 I believed: I'll never have sex until marriage. At age 18 I believed: If you are in love then sex is okay. At age 21 I believe: If you are both in the mood why not!" During the period of 1938-1950, only 7% of adolescent females reported having had intercourse. Today by age 20, over 80% of males and over 70% of females have had intercourse at least once (Hayes, 1987). So what has changed? Society in general seems more accepting of adolescent sexuality, premarital sex, and adolescent pregnancy than it used to be. The taboos, inhibitions, and stigma have decreased, and sexual activity has increased (Hechtman, 1989). Current trends in adolescent sexual behavior are the result of decades of development and change in social climate, social attitudes, and the organization and provision of services (Resnick, 1992).

According to the Canada Youth and AIDS Study, a national survey of 38,000 young people from Grades 7, 9, and 11 and first-year university students, 70% of Canadians in the 18 to 24 age bracket first had sexual intercourse when they were younger than 18 years old (King, Beazley, Warren, Hankins, Robertson & Radford, 1988). In comparison, 15% of the Canadian public 65 years and older and 40% of those aged 25 to 44 were under 18 at first intercourse. Among 15- to 19-year-olds in the United States, 53% of females and 60% of males have had sexual intercourse (Hanna, Hanrahan, Hershey & Greer, 1997). For those 15- to 24-year-olds who became sexually active before 18, 75% have had two or more partners since losing their virginity. This figure decreases to 45% for 15- to 17-year-olds and 40% for 18- to 19-year-olds if they have been sexually active for a period less than two years (Braverman & Strasburger, 1993). There has been a continuing trend towards a younger age at first-time intercourse. Today many adolescents begin their sexual experiences by age 14. With regards to sexual intercourse, 50% of Grade 11 students in the study by King et al. (1988) had intercourse at least once. This was also true for 26% of Grade 9 students and 12% of Grade 7 youth. Consistent condom use is reported among only 19% of first-year college/university students (King et al., 1988). This figure drops as age decreases. It would be overly optimistic to expect a dramatic increase in this percentage for comparable but more recent surveys. Health promotion goals for teenagers should include postponement of sexual activity until psychosocial maturity and consistent use of condoms by those who do engage in sexual intercourse (Committee on Adolescence, 1995).

A cost-benefit study conducted by Gans (1995) in the United States found that the treatment costs of preventable health concerns in teenagers is significant. For example, the treatment costs for adolescent pregnancies (including abortions and hospital costs for neonatal and low birth weight babies) amounts to approximately 1.5 billion (US$) per year. The cost of adolescent infections of STDs, HIV and AIDS totals 882 million, 122 million and 37 million (US$) respectively.

There are two very different opinions concerning the major influence on adolescent sexuality (Brooks-Gunn & Furstenberg, 1989; Millar, Christopherson & King, 1993). One camp has argued for the biological component to adolescent sexuality; namely, hormones and their effects on sex drive. A second has focused on contextual factors and their combined effects on adolescent development. The link between development and the initiation of sexual behavior is extremely complex and is strongly influenced by the social lens with which we view sex. Smith, Udry and Morris (1985) contend that social determinants of sexual behavior are stronger for girls, whereas biological elements carry more weight for boys. Such studies point to the need to understand simultaneously the roles of both biological maturation and social norms on the initiation of sexual intercourse and the engagement in other sexual behaviors.

Adolescence marks the beginning of pubertal events in which the childlike body is transformed to the adult shape. The onset of puberty brings a rapid increase in height and weight and the development of secondary sex characteristics, which eventually leads to reproductive capacity. Reproductive functioning and hormonal changes affect sex drive in complex ways (Moore & Rosenthal, 1993). Sexual maturation for girls and the onset of menarche usually occurs between 10 and 16 years, with a mean age for North American populations of around 12.5 years (Faust, 1977; Moore & Rosenthal, 1994). Not all teens develop at the same rate; there are male/female differences, with girls maturing on average two years ahead of boys. Although there are differences in development during adolescence, teens must also develop self-identity, autonomy, meaningful relationships, and a personal value system (Millar et al., 1993). This is a period characterized by rapid psychological changes and the need to achieve many significant developmental tasks, for both sexes.

Adolescent females have been studied much more extensively than males, and it has been found that a greater percentage of females are becoming sexually active at a younger age. This increased sexual activity leads to more sexual partners and increased risk of negative outcomes. Brooks-Gunn and Furstenberg (1989) wrote that early-maturing girls are more likely to have older friends, which is also associated with intercourse, smoking, and drinking. More physically mature girls seem to elicit more freedom from parents, perhaps making it more likely that they engage in dating and ultimately initiate early sexual behavior. Thus, girls who approach womanhood at a younger age tend to begin sexual experimentation before their predecessors. There are definite drawbacks to early initiation of sexual activities. A younger age of onset of sexual activity has been shown to increase the number of partners, decrease partner discrimination, and decrease the likelihood of condom use (Herold, 1994). Teenagers become more aware of their sexual attractions and love interests, and adult-like erotic feelings emerge. Gender identification occurs whereby one's existence as male or female is determined as to roles, values, duties, and responsibilities of being a man or a woman (Moore & Rosenthal, 1994).

The other side to the debate on the dominant influences of adolescent sexuality includes contextual factors. In general, children who enter adolescence with the most social or psychological disadvantages are likely to experience the greatest difficulties. Indeed it may be that the greatest barrier to healthy development is a lack of education and economic opportunities (Peterson & Leffert, 1994). Some researchers (to be discussed) claim that the initiation of sexual behavior is highly associated with what is perceived as normative in one's peer group. Others feel that parents play a pivotal role in the sexual attitudes and behaviors of teens. Finally, there is the contingent who feel that the media is an often-underestimated influence on today's youth.

Beliefs about the importance of peers in the initiation of sexual behavior are much stronger than the actual research evidence (Brooks-Gunn & Furstenberg, 1989). The research completed has not determined whether more sexually inclined youths seek to associate with more sexually experienced teens or if the grouping begins in advance of the initiation of sexual activity, and these influences are introduced to an established peer group. Moore and Rosenthal (1993) wrote that teenagers may obtain information from their friends, which may serve to guide decision making about sex. Having peers as the primary source of sexual information presents two major problems: (a) peers are notorious for being sources of misinformation, and (b) it is often very difficult to dispel the sexual myths that are pervasive among adolescents (Benshoff & Alexander, 1993). Adolescents can accept and reinforce peer attitudes regarding sexual behaviors. Teens may model their behavior after their friends or be "pushed" into activities through the processes of teasing, dares, and shaming. Benshoff and Alexander (1993) found that when teens talk about sex and relationships, research shows that they prefer talking to friends over parents at a ratio of approximately 2:1.

Research about parental influences on adolescent sexuality is surprisingly sparse. Issues of familial communication prior to first intercourse, aspects of communication in general, age when discussion of sexual topics occurs, and the context in which this is embedded are missing from published studies. One study found that the greater the number of sexual topics discussed by parents, the less likely the children are to have had coital experience or to have been promiscuous (Benshoff & Alexander, 1993). Parents also have a strong bearing on teen's opinions, beliefs and attitudes towards sex. Fundamentally, parents believe that they do not know enough about sexual topics to discuss them with their children. In another study, researchers found that parents may misjudge opportunities to discuss sexuality information; others may choose not to recognize their child's emerging sexuality and interest in sexual matters (Andre, Frevert & Schuchmann, 1989). In addition, Haffner (1998) revealed one aspect of the parental relationship with teens that discourages discussion of sexuality. Many teenagers are willing to risk pregnancy and disease rather than damage their reputation with their parents or experience the disapproval of adults with whom they must interact to obtain contraceptives and condoms. What is needed today are programs which include (a) increasing parent knowledge and comfort with sexuality topics, (b) helping parents to clarify their values related to sexuality issues, and (c) improving parent-youth communication (Benshoff & Alexander, 1993). The findings indicate that prior experience of discussion of sexual matters with others can facilitate responsible communication and sexual practices with sexual partners (Shoop & Davidson, 1994).

Media public awareness and educational campaigns represent efforts to educate adolescents about the risks of unsafe sexual activity, but effective education continues to be compromised by a lack of clear understanding of the specific kinds of messages that affect adolescent sexual decisions and practices (Shoop & Davidson, 1994). Television (TV) has gained a tremendous amount of popularity as a source of sexual health information for teenagers. In a recent study, 21% of all teens surveyed (up to 30% of males) chose TV as their number one preferred source (McKay & Holowaty, 1997). Still, TV subjects viewers to an estimated 14,000 sexual references and innuendoes per year, as compared to only 150 references to abstinence, contraception, or sexually transmitted diseases. A study looking at the most popular TV shows among those under 17 during the 1992-1993 broadcast season found that one in four interactions among characters per episode conveyed a sexual message. In three weeks of programming, only 2 of 10 shows included messages about sexual responsibility (Kaiser Family Foundation, 1996). Sex is used to sell beer and cars, but to date the major networks have refused to advertise birth control methods, fearing a backlash from viewers and commercial sponsors (McKay & Holowaty, 1997). The findings on adolescents' main and preferred sources of information about AIDS, STDs, birth control, and sex indicate that they acquired information about AIDS from TV, information about STDs and birth control from school, and information about sex from family members.

Adolescents and Risk Behavior

Adolescent risk taking has emerged as a leading public health concern. It is well established statistically that adolescents experience the negative consequences of some risk behaviors to a disproportionately high degree (Moore & Rosenthal, 1992; Quadrel, Fischhoff & Davis, 1993). According to Jessor (1991), *risk behavior* is any behavior that can compromise adolescent psychosocial development. Some adolescent risk behaviors are functional and purposeful, and often help adolescents achieve developmental goals. These behaviors may enable adolescents to gain peer approval, establish autonomy from parents, rebel against convention, cope with anxiety or frustration, or declare maturity—common issues that adolescents encounter during the transition to adulthood.

On the other hand, adolescent risk behavior is often attributed to exaggerated feelings of invulnerability. It is not clear whether experimentation is prompted by feelings of invulnerability and a willingness to take risks, or instead, simply reflects the failure of teenagers to perceive their own actions as unsafe (Cohn, Macfarlane, Yanez & Imai, 1995). Quadrel et al. (1993) wrote that the easiest explanation, in many ways, is that adolescents get into trouble because they do not understand the risks they are taking. A more troubling interpretation of risk behaviors is that adolescents actually understand the risks but choose to ignore them. A ready explanation for why adolescents take risks is that they ignore or at least greatly underestimate the likelihood of bad outcomes.

Development research suggests that adolescents undergo a transition from concrete to formal operational thinking at approximately 14 years of age. A lag time in this adjustment may render teens unable to think about situations hypothetically; thus they believe that natural laws do not affect them personally (Biro & Rosenthal, 1995).

Cognitively, early (11- to 13-year-old) adolescents are usually concrete, present-oriented thinkers unable to consider future consequences of their behavior. As they mature they develop the ability to think abstractly and anticipate long-range consequences. The limited cognitive and emotional abilities of early and middle (14- to 17-year-old) adolescents gives rise to egocentrism characterized by concern for one's own activities and needs. Teenagers may mistakenly interpret the risk of harm as cumulative across situations when it may actually be independent across situations (Cohn et al., 1995). This may explain why teens who have admitted to previous contraceptive use for example, find themselves currently engaging in sexual activity without protection.

Teens who are labeled sexual risk takers tend to have had multiple partners and do not use contraception when engaging in intercourse (MacDonald, Fisher, Wells, Doherty & Bowie, 1994). Research findings show that of all sexually active youth, 40% of those aged 15 to 24 have had four or more partners (Braverman & Strasburger, 1993). The reports from the Canada Youth and AIDS Study indicated that approximately 25% of the sexually active females in the study said that they did not insist that their partners use condoms. Of the males in this sample, 40% indicated that they had not used a condom in the past year of sexual activity (King et al., 1988). Luster and Small (1994) wrote that adolescent sexual risk takers differ from committed monogamists in that the risk takers had lower grades, were less religious, had less-positive relationships with parents, and engaged in other high-risk behaviors such as smoking marijuana and using alcohol. The presence of these other high-risk behaviors is a key marker for high-risk sexual activity because the disinhibiting effects of various substances may alter decision-making abilities, thereby increasing the person's likelihood of engaging in high-risk sexual behavior or failing to use appropriate barrier devices (Krowchuk, 1998). It is also known that these factors do not occur in isolation and that substance use and sexual activity are frequently linked. Shrier, Emans, Woods and DuRant (1996) found that students with more sexual partners are more likely to have greater frequency and severity of lifetime and recent drug use.

Individual and familial factors have been identified which determine whether some adolescents will be risk takers and others will not. Individual indicators include low academic skills and educational aspirations, recent initiation to intercourse, and tendencies toward risk-taking behavior in general (Langille, Beazley, Shoveller and Johnston, 1994; Melzer-Lange, 1998). These tendencies can manifest as multiple problem behaviors and have been defined in the literature as school failure, history of juvenile offenses, psychiatric disturbances, and early unintended pregnancies or STDs (Hein, Dell, Futterman, Rotheram-Borus & Shaffer, 1995). Familial indicators include diminished parental education, a lack of communication of a sexual nature between parents and their children, having a mother who had given birth as a teen, and a generally strained relationship between the parents and the teen (Brooks-Gunn & Furstenberg, 1989; Hayes, 1987; Luster & Small, 1994).

Not all teenagers are faced with the same probability of encountering the negative outcomes of sexual activity. There is a subgroup of youth in our society whose susceptibility is determined by much that is beyond their control. Teens who are socially, economically, or ethnically disadvantaged tend to begin sexual activity at an earlier age and are less likely to use contraceptives when they do have sex (Rotheram-Borus, Becker, Koopman & Kaplan, 1991). Factors which increase these teens' risks include having a family from a lower socioeconomic status, having below-average grades or not attending school at all, being unemployed, living with only one parent, and having parents who are not college graduates (Wattleton, 1987). Street youth who are characterized by sexual promiscuity and substance use are very likely to be spontaneous and dangerous when it comes to sexual activity (King et al., 1988; Rotheram-Borus et al., 1991). Street kids do not necessarily sleep in garbage cans or in boxes in alleys but may intermittently run from the supervision of social services, whereas others live at home but spend a great deal of time on the streets. Adolescents' natural bent to experiment sexually, when combined with drinking alcohol and using drugs, can lead to unplanned and unprotected sex (King et al., 1988).

Although adolescent risk perception has been discussed as a separate section within this literature review, aspects of risk and its relation to adolescents will be woven into the subsequent discussions of teen pregnancy, STDs, and HIV/AIDS.

Adolescents and HIV/AIDS

The World Health Organization (WHO) estimated that half of the 14 million people infected with the human immunodeficiency virus (HIV) worldwide were infected between the ages of 15 and 24 years (Hein et al., 1995). Adolescents currently account for only a small fraction of the total number of reported acquired immunodeficiency syndrome (AIDS) cases. However, the nature of adolescent sexual behavior in combination with the heightened exposure risks of some teenagers have raised serious concerns regarding the vulnerability of the adolescent population to further acquisition and transmission of this infection (Goldsmith, 1993; Overby & Kegeles, 1994). It is reasonable, then, to speculate that HIV may be transmitted through the adolescent populace at a relatively fast pace.

National and international studies of HIV seroprevalence reveal that adolescents, particularly adolescent females, are now being infected at higher rates than the adult population (Health Canada, 1999). For example, in Canada, the proportion of HIV-positive test reports among young women is increasing. During the first six months of 1998, 20.5% of new HIV positive results were among women, compared to 19.4% in 1995 and 10.1% between 1985 and 1994 (Health Canada, 1999). The mode of HIV transmission has also shifted during the past two decades. The proportions of HIV cases which derive from heterosexual contact have also risen dramatically. No longer a plague of the gay community, heterosexual transmission has increased from 7.5% during the period 1985 to 1994 to 24.7% in the first half of 1999.

Recent figures indicate that AIDS, unheard of before 1981, is now ranked sixth among causes of death in young people aged 15 to 24 years in North America (Oskamp & Thompson, 1996). Health Canada and the Centre for Disease Control (CDC) in the United States reported that approximately 0.5% to 1.0% of reported AIDS cases occur among the 13- to 19-year category, and close to 20% of all adults diagnosed with AIDS are under 30 years of age (Hanna et al., 1997; Health Canada, 1999). Heterosexual transmission of AIDS among teenagers is a significant problem. Given the latency period from the time of HIV infection and the onset of AIDS, many of those who are diagnosed with the disease in their 20s actually acquired it in their teens (Imperato, 1996; Maxwell, Bastani, & Yan, 1995). Once one is exposed to HIV, AIDS symptoms appear on average 2 to 7 years after infection but may not manifest for up to 10 to 12 years (Gallbraith et al., 1996; Hanna et al., 1997). An alarming trend is the finding that the number of adolescents in North America with AIDS appears to double every 14 months (Nelson, 1995).

Epidemiological data show the prevalence of a number of high-risk behaviors among adolescents that increase the probability of HIV infection (DiClemente, 1992). These behaviors may include inconsistent contraceptive/condom use among sexually active adolescents, multiple sex partners, and an overall low perceived risk of infection (DiClemente, 1991; Ramsum et al., 1993). Unprotected sex with multiple partners, behavior more frequent after the use of drugs and alcohol, is contributing to the rapid transmission of HIV in this age group (Maxwell et al., 1995). Adolescents in a higher risk bracket for HIV infection include juvenile delinquents, abused and neglected children, and youth who run away from home (Slonim-Nevo, Auslander, & Ozawa, 1995). Slonim-Nevo, Ozawa and Auslander (1991) found that delinquent and abused youth in residential facilities were highly knowledgeable about HIV transmission and AIDS, but had few positive attitudes towards prevention and acknowledged engaging in unsafe AIDS-related behaviors.

Despite the rapid development of educational HIV/AIDS prevention programs and widespread safer sex messages, the adoption of safer sex techniques has not been consistent with the increased knowledge of the effectiveness of these behaviors. Bowler (1992, p. 348) wrote that

> "Adolescents from North America and many westernized countries are likely to be the most difficult age group to influence towards HIV/AIDS prevention due to their (1) susceptibility to negative peer pressure; (2) propensity to take risks, including sexual and drug experimentation; (3) sense of invulnerability and immortality; and (4) difficulty in grasping long-term, adverse consequences of current behavior."

HIV is no longer, as it was commonly considered, a disease affecting only the gay community, IV drug users, and street sex workers; but is a real threat to the adolescent community as a whole. Although predictions about the scale of the AIDS epidemic are limited by the scarcity of information about sexual activity in young people, epidemiological data suggest that the epidemic within the adolescent population will continue to grow (Bowie & Ford, 1989; Gallbraith et al., 1996; Nelson, 1995; Strunin, 1991).

Adolescents and Sexually Transmitted Diseases

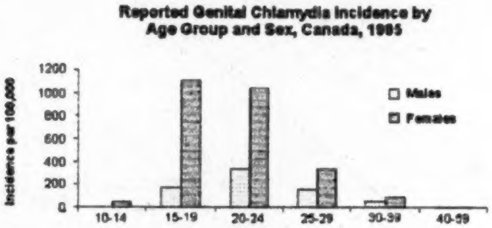
In Western society, sexually transmitted diseases (STDs) are predominately diseases of adolescents and young adults (Oskamp & Thompson, 1996). Despite continued decreases in Canadian STD rates, STDs remain an important public health problem in Canada. Adolescents, especially high-school-aged youth, constitute a group at higher risk for STDs compared with other age groups of older adults (Svenson, Varnhagen, Godin & Salmon, 1994). In the United States, 2.5 million teenagers each year contract an STD, and of those youth who are sexually active, one in four will acquire an STD before graduating from high school (Krowchuk, 1998).

A number of factors have been identified as contributing to the widespread prevalence of STDs in the adolescent population. These determinants include poverty, lack of access to adequate health care, privacy concerns, discomfort accessing health care settings, residing in communities with a high risk of STDs, and lack of transportation (Betz, 1998; Krowchuk, 1998). Behavioral risk factors related to sexually transmitted infections (STIs) include initiating sexual intercourse at an earlier age, engaging in unprotected sex with inconsistent or no condom use, having intercourse with partners with high-risk profiles, and having multiple partners (Shrier et al., 1996). Poulin et al. (1997) also noted the influence of substance abuse and the amount of alcohol consumed per week on the decision-making processes of adolescents.

One should not overlook the impact that STDs have on teenagers' future reproductive health. In women, STDs and the resulting sequelae can cause both acute and chronic pelvic inflammatory disease (PID), difficulties with conception due to tubal infertility, pregnancy loss due to ectopic pregnancy, spontaneous abortion and stillbirth, premature delivery, and adverse pregnancy outcomes such as neonatal ophthalmia and neonatal pneumonia (Health Canada, 1998). Men can suffer long-term consequences of epididymitis and infertility. In Canada the costs of PIDs alone are approximately $200 million annually. It is estimated that $4 billion to $5 billion are spent each year treating the sequelae of STDs in the US (Lappa, Coleman & Moscicki, 1998). It has been suggested that HIV/AIDS education has overshadowed STD education, even though chances for contracting an STD are far greater than those for AIDS (Herold, 1990). Health Canada prepared the following information (1998).

Chlamydia

In Canada chlamydia became a reportable STD in 1990. It is the most commonly occurring bacterial STD, with 37,551 cases in 1995. Because 70% of cases in women and 30% in men are asymptomatic, the figures could be two to three times higher than reported. Young people aged 15 to 24 years have the highest rates of chlamydial infection, with a ratio of female to male infection at 3:1 (Figure 1). Seventy percent of all reported cases in Canada occur within the age group of 15 to 24 years. Within this age bracket, women had the highest reported rate of 1109.10/100,000 cases, which is nine times the national rate of 126.8/100,000 cases. Screening of sexually active adolescents yielded prevalence rates of 15%, yet this figure does not take into account the underreporting of male statistics due to an unwillingness to provide a urethral swab.



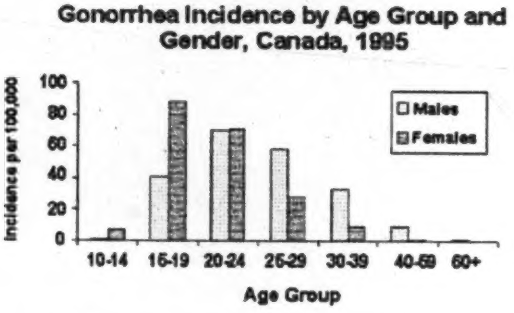
Reported Genital Chlamydia Incidence by Age Group and Sex, Canada, 1995

Division of STD Prevention & Control Bureau of HIV/AIDS & STD, LCDC

Figure 1. Chlamydia Incidence, 1995

Gonorrhea

Gonorrhea is the most common STD in the world, although not in Canada. In 1995, 51.4% of reported cases of gonorrhea were in the 15- to 24-year age group (Figure 2). The highest reported rate of gonorrhea in Canada was in females between the ages of 15 and 24 at 87.8 cases/100,000, five times the national average. Prior to 1995 the peak incidence for Canadian women was in the age group 20 to 24. Thus there has been a shift in peak incidence towards younger females, and because 70% to 80% of females have no noticeable symptoms, rates could be higher still.

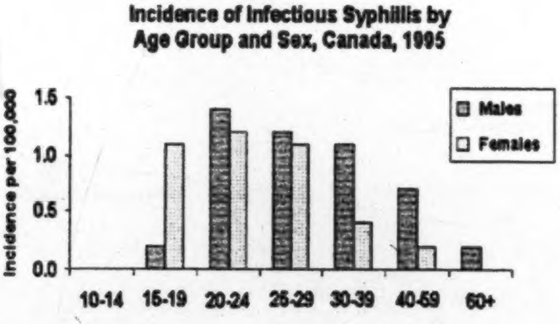

Gonorrhea Incidence by Age Group and Gender, Canada, 1995

Division of STD Prevention & Control, Bureau of HIV/AIDS & STD, LCDC

Figure 2. Gonorrhea Incidence, 1995

Syphilis

Syphilis in Canada is potentially close to elimination level. Today only 0.5% of all reported diseases are syphilis. The highest reported case rates of infectious syphilis were seen in the 20- to 24-year age group (Figure 3), and in general females are affected at younger ages than males. Rates in the US, however, are increasing among heterosexuals, especially young women; thus syphilis rates may be maintained above the elimination level by cases "imported" into Canada.


Incidence of Infectious Syphilis by Age Group and Sex, Canada, 1995

Division of STD Prevention & Control Bureau of HIV/AIDS & STD, LCDC

Figure 3. Syphillis Incidence, 1995

Adolescents and Pregnancy

> Not so long ago, a boy was highly motivated not to get a girl pregnant. There were the undesirable possibilities of a shotgun wedding and having to drop out of school to look for work to support a new family. Likewise, the girl had to face the degradation and humiliation of an out-of-wedlock pregnancy. Clearly differentiated male and female sex roles, and the strongly accepted social belief that one should control sexual desire in anticipation of a happy and permanent marriage and parenthood helped adolescents of the past to refrain from early sexual activity. [Recent] scripts are murky at best (Black & DeBlassie, 1985, p. 282).

The above quote is an example of how, over the past generation, marked shifts have occurred in attitudes toward out-of-wedlock pregnancy, single parenting, abortion, and adoption. Although rates of teen pregnancy had apparently reached a plateau in North America in the mid-1980s, since 1987 and continuing through 1994 the adolescent birth rate has again risen (Klerman, 1993). Adolescent pregnancy and parenting have remained a concern in American society for many years. The US maintains the highest rate of teen pregnancy of all Western, industrialized countries at 56.9/1,000 births in the age range of 15- to 19-year-olds. Canada sits at approximately 26/1,000 compared to (a) Japan, 4/1,000; (b) Norway, 32/1,000; (c) Great Britain, 32/1,000; and (d) Germany, 10/1,000 (Moore, 1996). Yet this rate takes into account only the pregnancies which result in live births.

Canadian statistics refer to the teen pregnancy rate as the sum of live births, therapeutic abortions, and miscarriages/stillbirths (Wadhera & Millar, 1997). Generally speaking, the pregnancy and abortion rates among American teenagers are more than twice as high as those among their Canadian counterparts (Hechtman, 1989). In 1994, close to 47,800 teen pregnancies were reported by Statistics Canada. Thus, 1 in 20 females in the age range of 15 to 19 years become pregnant every year. Of these 24,000 babies born to teenage women aged 15 to 19, an estimated 21,000 were aborted, and 2,000 miscarriages/stillbirths occurred (Wadhera & Millar, 1997). Historically speaking, the 47,800 pregnancies that ended in 1994 were up from 39,000 in 1987, but well short of the total of 61,964 that ended in 1975. Alberta teens have a rate of teen pregnancy even higher than the national average at 33.0/1,000 live births. This province reports an average of 3,500 live births to teens annually. Alberta Municipal Affairs (1995) reported 39 births to young women less than 15 years of age and 3,046 births to girls 15 to 19 years.

The estimated number of pregnancies and pregnancy rates to women aged 15 to 19 years have risen considerably since a low of 39,340 pregnancies in 1987 and may continue to do so unless further steps are taken to bring adolescent sexuality under control (Wadhera & Millar, 1997). Whereas the pregnancy rate continues to increase (41.1 per 1000 women aged 15 to 19 in 1987 to 48.8 per 1000 in 1994), there has also been a major shift in the outcomes of teenage pregnancies (Millar, 1995). The percentage of adolescent births occurring outside of the union of marriage has been rising since the 1960s and in 1994 was 76%. Of the 96% of girls who keep their babies, fewer than half marry; thus the largest percentage of these girls become single parents (Black & DeBlassie, 1985). The proportion of unmarried adolescents who place babies for adoption is approximately 5%. This represents a complete reversal of patterns evident 40 years ago when approximately 95% of teens who gave birth opted for adoption (Resnick, 1992). Wadhera & Miller (1997) reported that in 1974, 66% of such pregnancies in Canada had ended in live birth, 26% in therapeutic abortion, and 8% in a stillbirth/miscarriage. By 1994, the majority (51%) of teen pregnancies ended in a live birth, and almost as many (45%) ended in an abortion. In North America today, roughly 43% of all teenage pregnancies end in abortion, with younger teens using this option with much less frequency than girls 17 years and older (Morgan, Chapar & Fisher, 1995; Schwab-Zabin & Sedivy, 1992). Yet a surprising shift reflects an abortion rate for teens 15 to 17 years old which exceeds live birth rates: 14.9 abortions versus 13.9 live births per 1000. Resnick (1992, p. 299) wrote that

> while individual cases vary, adolescents who terminate a pregnancy, in comparison with those who carry to term and parent, are characterized by higher educational aspiration, motivation, and attainment; better school performance; greater economic resources; greater capacity to think hypothetically about the future; a more internalized locus of control; more favorable attitudes toward abortion; and a more distant relationship with the male partner.

There is a general consensus in the published literature that there is no single cause for the rising rate of adolescent pregnancy, but rather a multiplicity of factors that contribute to it. School-aged girls who become pregnant come from all socioeconomic classes and from both public and private schools. An analysis of the age and geographic distribution of teen pregnancies suggests that the youngest and largest numbers occur in the lower to lower-middle-class area of the cities under investigation (Hechtman, 1989). Teen pregnancy is more prevalent in lower socioeconomic groups, in minority groups, and among teens living in large urban areas. The analysis reported that teens learn much from their peer group; and "normal activities" such as drug use, alcohol use, and becoming pregnant are viewed only as a "matter of time." Klerman (1993) observed that if poor adolescents are to act like nonpoor adolescents in regards to sexuality, pregnancy, and child rearing, society will need to offer them comparable life circumstances; for example, adequate family incomes, contact with positive role models, better schools, and improved housing.

For those adolescents who plan to raise their children themselves, many other factors come into play. There are multiple dimensions to the teen-pregnancy phenomenon, including physiological, social/psychological, and environmental contributors. There is a belief that pregnant adolescents experience poor pregnancy outcomes. This occurs in part because the rates of maternal pregnancy complications, low birth weight, or neonatal mortality are higher among adolescents than among older women; but these differences are more likely due to poverty rather than age per se (Jacono, Jacono, St. Onge, Van Oosten & Meininger, 1992; Klerman, 1993). Adolescents with lower socioeconomic status generally receive insufficient prenatal care, poor education, and inadequate nutrition, and suffer from more stress than older women do during their pregnancies (Klerman, 1993). Pregnant adolescents suffer from a higher incidence of toxemia, anemia, hypertension, nutritional deficiencies, urinary tract infections, abruptio placentà, and prolonged labor (Black & DeBlassie, 1985; Stevens-Simon, Kelly, Singer & Cox, 1996). Adverse perinatal outcomes also occur with greater frequency with teen mothers. Babies may be born prematurely; often of lower birth weight; stillborn; or with underlying health problems that cannot be immediately identified (Wadhera & Millar, 1997). Other factors leading to the poor prognosis of teen pregnancies is habitual use of alcohol, cigarettes, and drugs. Child-bearing adolescents may be at even greater risk of contracting HIV than the general population of youth because they have often initiated sexual activity at an earlier age, are likely to remain sexually active, and may have multiple partners over the long course of their child-bearing years (Koniak-Griffin & Brecht, 1997).

Much uncertainty comes with becoming a pregnant teen. The crisis of adolescence is complex with issues and conflicts regarding identity, dependence, autonomy, and control. Pregnancy complicates this crisis by making the adolescent more dependent, allowing her fewer options, and significantly impeding her sense of autonomy and control (Hechtman, 1989). Specifically, the young girl must face issues of body image, self-esteem, and additional stressors such as finances, childcare, and housing and food concerns.

Social relationships also suffer under the burden of impending motherhood. It may be a time of awkwardness between the pregnant teen and her family, friends, and partner. The relationship with the male partner has been shown to be an important aspect to the teen mother's coping ability. Although the male might remain throughout the course of the pregnancy, teen marriages have thus far been largely unsuccessful. Teen mothers are more likely than their childless peers to marry by age 20, and their marriages are more likely to end in discord and divorce (Furstenberg, Brooks-Gunn, & Morgan, 1987). One in five teen marriages end in divorce within the first year and three in five within six years (Oz & Fine, 1988). Even subsequent relationships and marriages tend to be troubled. Dating becomes difficult, with time and attention given to the infant. Isolation from friends who do not have the same limitations on their time and money often results (Hechtman, 1989). Childbearing, marriage, and divorce further separate teen mothers from their contemporaries and contribute to social isolation. Adolescent challenges are greatly affected by life events that alter the provision of adequate social support and absent or interrupted social relations. There are signs that childbearing during adolescence seriously jeopardizes the quality of life of most young parents and their children. Teens cannot assume the economic, social, and psychological responsibility of childcare and child rearing (Stevens-Simon et al., 1996).

There is considerable evidence to show that girls who become pregnant as adolescents are below average in their school performance and achievement test scores, even before they conceive. Coupled with a history of difficulties and disinterest in school as well as low educational and vocational aspirations, many girls drop out of school and further compound their financial crisis. Adolescents, particularly females, quickly realize how difficult it becomes to support a family without a high school diploma and must turn to welfare services to make ends meet (Klerman, 1989). It takes a considerable amount of time and energy for a young girl in this situation to achieve financial independence; most do not reach this goal.

Many theories exist as to why teen pregnancy remains a prevalent health concern. It is well known that although most hypotheses remain inconclusive, early sexual initiation impacts on teen pregnancy. An early stage of onset of five other problem behaviors was also associated with adolescent pregnancy. Jessor (1991) argued that risk and problem behaviors such as cigarette smoking, smoking regularly, drinking alcohol, trying marijuana, and trying cocaine tend to cluster among adolescents. Young people who have had early experience with cocaine, tobacco, and sexual experimentation had a higher risk for getting pregnant while still in high school (Spingarn & DuRant, 1996).

In a study by Stevens-Simon et al. (1996), a minority of pregnancies appeared to have been entirely accidental. Only 12% attributed their pregnancies to contraceptive failure, and the most frequently cited reasons included, "I didn't mind getting pregnant" and "I wanted to get pregnant." The total life situations of low-income teens in particular have had an impact on their motivation to become involved in sexual relationships. Some girls become pregnant in hopes of receiving more attention from family and friends, some may wish to produce a highly valuable companion or pet for themselves, and some may try to obtain commitment of affection and exclusivity from their partners (Black & DeBlassie, 1985).

Currently, we are seeing a teen birth rate that is in danger of rising to the levels present in the mid-1970s. It is evident that an increasing number of young women are turning to abortion as a solution to their predicament and that those who decide to carry their babies to term are choosing to parent their children rather than give up their babies for adoption. In any case, these results suggest that young people need the motivation to avoid childbearing as much as they need knowledge and access to contraceptive services. As a result of the increasing teen pregnancy rate, society has to bear the burden for supporting health and social service programs in an effort to manage the economic and human costs of adolescent single parenting (Klein, 1998).

CHAPTER III

METHODS

Rationale for Qualitative Methodology

The essence of qualitative research is that it seeks to investigate with attention to the social context in which meaningful events occur and with emphasis on understanding the social world from the participants' perspective (Cobb & Hagermaster, 1987). Qualitative research is interpretive, naturalistic, and inductive. It is a multimethod approach, with an emphasis on processes and meanings. Qualitative researchers study phenomena in their natural settings and try to understand the meaning that people give to experiences in order to describe and explain phenomena and develop explanatory models and theories. Qualitative methods are useful when little is known about the subject matter and are suited to questions seeking individual experience. The purpose of this study was to describe the underlying issues and concerns of today's youth regarding their sexual behaviours and their risk of the negative outcomes of sexual activity. Qualitative methodology was appropriate because, as previously mentioned, the emic perspective or native experience has been limited in studies focused on adolescent sexuality.

Existing research identifies the many factors that influence adolescent sexual behaviors. There are few qualitative studies, however, that have presented the impacts of these influences from the adolescents' perspective. An exploratory descriptive study using ethnographic methods was utilized to answer the research question. Ethnography is based on an understanding of culture. How we act, think, or do is a reflection of this 'culture.' Ethnography attempts to understand the guidelines for culturally constituted behaviors to determine why certain behavior occurs and under what circumstances (Spradley, 1979). The design was based on the assumption that culture is learned and shared among members of a group and, as such, can be described and understood (Morse, 1994). A focused ethnography seeks to study a select group, social unit, or specific topic of interest. Instead of applying the methods to the study of an entire culture, one can apply the ethnographic, holistic approach to understand adolescent sexual behaviour and perceptions of risk. For the purpose of this study, the culture under investigation was adolescence with a focus on the sub-culture of at-risk youth. In addition, the topic of the research was selected before data collection began and thus did not emerge from the data, as is the case in classical ethnographies (Morse & Field, 1995). In this study, adolescents provided a unique culture with a well-developed language and set of behaviors. Under the umbrella term of *human sexuality*, issues and perceptions of risk (e.g., HIV/AIDS, STDs, and pregnancy) were discussed and illuminated by shared experiences from the participants' point of view. Based on the literature review, more information about these perceptions was required to enhance understanding. Ethnographers do not study people; they learn from people in an emic, holistic, reflexive, and contextual fashion.

Procedures

A "true" ethnography involves three specific components: participant observation, interviews, and documented fieldnotes. Due to the topic of the study, it was not possible to blend into a teen group to observe sexual behaviors and the decision-making processes of adolescents. For this reason an exploratory descriptive study was employed using primarily components of the ethnographic interview, documented fieldnotes, and, to a lesser extent, participant observation.

Understanding the culture of adolescents with regard to perceptions of sexuality and risk of sexual behavior required that a relationship of trust be established and a context for the findings determined. Limited periods of observation of the target group were conducted primarily in the early stages of the research and continued throughout the course of the data-gathering period. This meant that the researcher spent time "hanging out" at the chosen youth agency to observe youth and to familiarize herself with the programs in which they were involved. After the initiation of the interviews, efforts were made to come to the club early to talk informally with club members and former interviewees. All data presented were based on self-reports. Several techniques were used to maximize rapport and accurate self-disclosure. Pseudonyms rather than actual names were used in the written reports, and informed consent forms were kept separate from the transcripts. The participants were assured that their responses would remain anonymous. More sensitive questions were asked in the latter part of the interview after rapport was established. Initially, questions were asked which focused more on general family/school background rather than probing personal sexual history. Through the interviewing process, the aspects of culture most important to the youths were identified. By asking the adolescents themselves how best to observe and learn about their culture, a clearer picture of the context for adolescent sexual behavior and risk-taking actions was developed.

The Sample

Volunteer and purposeful samples were acquired to maximize the experiences sought and to select the best potential informants with the desired experiences. Advertising for participants in clinics, outreach centers and youth group offices did not prove to be an effective way of recruiting adolescents who were willing to be interviewed. Although numerous posters advertising the study were circulated, not a single participant was recruited by this means. Purposeful sampling was deemed the only approach to collect an adequate sample size. Interview participants were composed of a purposeful convenience sample obtained exclusively from a youth-oriented independent living program in a Northern Alberta urban youth agency. This specific independent living program functions to assist youth in gaining their independence. Child welfare, youth accommodation, support, and supervision are offered to assist adolescents in developing living skills as well as decision-making, communication, conflictmanagement, and parenting skills. Youth involved in the program work toward a successful and responsible transition to independent living. This partnership with the independent living program was most valuable in the acquisition of a sample. With the help of the Program Director, the researcher was able to meet and interview 10 adolescents. All information regarding responders was kept confidential; thus there was no direct involvement of the healthcare/outreach workers, and services were not jeopardized.

In addition to these 10 participants, two pilot interviews with neighboring adolescents were completed to assess the interview protocol. No major revisions were made to the protocol as a result of the pilot interviews. The data from the pilot interviews are not included within this study.

The study participants were chosen because they had knowledge of or experience with the topic under investigation and because they would be "good" informants (articulate, reflective, and willing to share with the interviewer; Morse, 1991). The selection criteria were as follows:

- 15 to 19 years old
- from within the Edmonton area
- able to speak and understand English
- able to commit to at least two- to three-hour time periods for interviews.

Informants may/may not have been enrolled in formal education classes at the time of the study. They may/may not have had previous sexual experience. The participants were of both genders, from a variety of ethnic backgrounds, and fluent in the English language. Potential participants were informed of the purpose and topic of the study before agreeing to be interviewed, and selection occurred based on their desire and willingness to discuss their sexual experiences.

The exact sample size necessary to describe the underlying issues and concerns of today's youth regarding their sexual behaviours and their risk of the negative outcomes of sexual activity was impossible to know before the study commenced. Sampling continued until the researcher had "heard everything" and felt able to describe behaviors and perceptions fully from the emic perspective. This process, known as *saturation*, dictates that sample size is not predetermined but is decided by the data adequacy (Morse & Field, 1995).

Data Collection

Semistructured interviews with adolescents who met the inclusion criteria were the principal means of data collection. The semistructured interview is used when the researcher knows little about the topic and is learning as the interview process progresses. These interviews are free flowing, open ended, and responsive to the information and cues provided by the participant. All interviews in this study were conducted in a private office within the youth agency's main center. Allowing the participant the opportunity to come to a familiar setting released some of the initial anxiety and served to increase the rapport between interviewer and interviewee (Morse & Field, 1995).

Ten interviews were conducted over a four-month period. All interviews had an informal and relaxed atmosphere and were anywhere from 45 to 100 minutes long. To initiate the interview, the purpose of the study and the rights of the participant as a member of the study, as outlined in the informed consent, were reviewed. Background data were then solicited from each participant so that the study sample could be characterized regarding age, ethnic background, parentage, occupational aspirations, health behaviours and hobbies (Appendix A). The inclusion of the demographic data also helped participants to become comfortable with the interviewer and put their responses into context. All interviews were tape recorded and later transcribed verbatim by a transcriber. The interview was used to draw from adolescents their perceptions and experiences.

The interview guide consisted of questions and prompts organized into five different themes (background, sexual experience, general risk, self-risk, and education; Appendix B). The section titled *Background* was added after the first three interviews had taken place because it was determined by the researcher that this section could serve as an effective entry point to the more personal questions which were to follow. Initially, broad, general questions (e.g., on family, school, and health opinions) made the participant more comfortable with the interview. The development of this interview guide was based on the study question, relevant literature, and questionnaires, and interview schedules used in other research studies (Edwards, 1995; Fletcher, 1994; Mykietka, 1998). Semi-structured interviews allowed the researcher to maintain order and consistency from interview to interview, yet also gave the participants free rein over their responses and the direction they wished to take with the individual questions.

In addition to the interviews, fieldnotes were recorded immediately after periods of observation and/or interviewing. These notes were dated and transcribed along with the materials collected from the observations and interviews. Fieldnotes served to add depth and commentary to the data regarding the sequence of events and missed notes from the other data forms. Personal notes were kept to jot down hunches, subjective biases, and reflections about the research process.

Data Analysis

Data analysis in qualitative research requires intense questioning and a relentless search for answers, active observation, and accurate recall. Analysis and data collection occur simultaneously so that leads discovered through analysis can be followed up in data-collection stages. The actual process of qualitative data analysis includes synthesization of data, which leads to the aggregation of categories, strategies for linking categories, and decisions and processes of falsification and confirmation in theory development (Morse, 1994). Ethnography makes use of four cognitive processes integral to all qualitative methods: comprehending, synthesizing, theorizing, and recontextualizing (Morse, 1994; Morse & Field, 1995).

Comprehension

In ethnography, comprehension increases as data collection proceeds. This stage of analysis involved "becoming familiar with" and "making sense" of the data. This was a time of peak observation and intense interviewing as the data moved beyond the general to the specific. This stage was especially relevant to studying adolescents, because they possess a unique set of rules and behaviors that required understanding in order to "fit in" and establish a connection with the group. At this time patterns of experience were identified and predictions made as to what the first-level codes might look like. Once the transcripts had been completed, textual analysis occurred whereby the verbal text was tagged, cut, and labeled so that it could be separated from the body of the transcript and eventually traced back to the original source. Color coding key phrases, concepts, and behaviors was one way of breaking up the data to extract statements of emerging ideas or incidences that described risk in sexual behavior. Saturation became explicit when the researcher had 'heard everything' and could fully describe behaviors and actions from the emic perspective (Morse & Field, 1995).

Synthesization

Synthesizing the data required "sifting" and "weeding through" the information collected. Coding of the data continued as information from all transcripts and notes were pooled together to form categories, linking the data themes together where appropriate. Coding, as a central process, helped the researcher sort the data and uncover the underlying meanings in the text and metaphorical references, and brought both the central and peripheral referents to the researcher's attention (Morse, 1994). At this time norms were emerging from the data, and the researcher was able to describe aggregate themes and see relationships among participants and categories. Conjecture and verification processes facilitated the presentation of detailed descriptions of the participants' experience.

Theorization

Theorizing demands that the data be sorted to construct alternative models for the data and rule out the possibility of other explanations for the phenomena. During the data-collecting process, memos on "theoretical notions" were made and pooled. Here the emic-etic linkages were compared as the participants' related experiences were compared to the researcher's observed activity.

Recontextualization

Recontextualization was the development of the emerging themes so that the themes were applicable to similar settings and groups. Theme-based generalizations within a specified context were critical to uncovering cultural universals and comparisons which could ultimately be used to modify behaviors.

Descriptive analysis allows for the development of ideas and tests them against observations, which are then modified and tested again. This process facilitates a deeper insight into the data and how the pieces of information fit together to develop themes. The methods employed to analyze this data set were unique in many ways. In order for others to repeat these methods, it is relevant to outline the framework used in this study.

Analysis by Question

Analysis by question (Phase I) was initially used to sort through the transcripts according to the questions asked during the interview process. Each question from the interview protocol was addressed individually, with responses cut from the transcripts which "fit" the questions asked. For example, with the question "What do you see as your biggest risk of sexual behavior?" the researcher systematically went through each transcript, cutting out only those responses, which stemmed directly from this particular question. This was an efficient way to sift through and become familiar with the transcripts and the most salient questions. This procedure also facilitated the discovery of additional information not directly solicited from the protocol.

Analysis by Transcripts

After mapping out what served to be the relevant themes in the data sets, the researcher proceeded to sort through each transcript individually, cutting out passages which reflected the essence of the guiding research question (Phase II). This process was increasingly hands-on as each transcript went through a series of modifications, including:

- Each transcript was copied onto a different colored paper (12 colors)
- Responses were cut from the transcripts (line number included) and placed into envelopes denoting the common themes and categories derived from Phase 1.
- New themes and categories were created as needed, and subcategories were developed as information was differentiated.

Both Phase I and Phase II methods of data analysis effectively maximized the use of all data collected from the interviewing process and enabled information to move between themes and categories, as needed, while retaining the source of the comments.

Rigor

There are numerous ways that qualitative research can be evaluated for rigor. When evaluating the participant data in qualitative research designs, two properties can be looked at: *adequacy* and *appropriateness* (Morse & Field, 1995). Adequacy refers to the sufficiency and quality of the data. To ensure adequacy the data were considered complete, and loose ends were tied up. Sampling continued until no new information was presented and the amount of data were sufficient to draw conclusions. The quality and stability of the data were assured by asking participants similar questions over time to establish consistency of their answers.

The question of why adolescents would give a complete stranger accurate information can be answered as follows. After an explanation of the purpose of the study, the adolescents understood that their opinions were valued and desired. The participants were assured anonymity and the freedom to discuss only those issues they felt comfortable sharing. The development of rapport between the researcher and participant further ensured accurate information-sharing.

Appropriateness pertains to the methods used to facilitate understanding of the research topic. In this study the researcher has outlined many possible avenues for data collection and participant sampling in an attempt to generate the most reliable information possible. With regards to the study as a whole, determining rigor involves the assessment of trustworthiness or whether a researcher can persuade his/her audience that the research findings are worthy of attention (Morse, 1994). The criteria for establishing the trustworthiness of qualitative research include credibility, fittingness/applicability, auditability, and confirmability.

"The credibility of qualitative research is enhanced when the investigator describes and interprets their own behavior and experiences as researchers in relation to the behavior and experiences of participants" (Sandelowski, 1986, p. 30). Credibility was achieved through increased time in the field to fully understand the context of the study. The data are strengthened by the knowledge that the "truth value" lies within the lived experience of the participants and, in turn, their ability to verify the accuracy of the researchers' descriptions and conclusions. The researcher provided a random selection of tapes to the supervisor to check the accuracy of the coding and content analysis; thus the internal consistency of the interviews was established and judged by both the researcher and the supervisor. When differences between the researcher and the supervisor occurred, a fellow researcher was asked to review the tapes and facilitate the process of consensus. This use of multiple raters takes into consideration researcher bias due to emotional attachment to the data (Morse, 1994).

Fittingness is used to determine whether the research findings can be applied to other similar groups or contexts and whether the findings 'fit in' with the literature. "The researcher must establish typicality or atypicality of observed events, behaviors, or responses in the lives of the participants"(Sandelowski, 1986, p. 32). The participants may not be representative due to small sample size and purposeful sampling; however, the data should be representative of adolescent sexual behaviours. Obtaining validation from the participants themselves was sought through the use of summary-type questions during the later interviews.

Auditability is the major technique for establishing dependability and suggests that another researcher could come to similar conclusions given the same data and research context. This process was ensured through accurate record keeping of the fieldnotes and observations, noted changes in methodology or analysis techniques, and meticulous recording of personal-reflection memos. The findings must be comparable if repeated by another researcher.

Confirmability refers to the findings themselves, not the subjective or objective stance of the researcher (Sandelowski, 1986). Confirmability was achieved when credibility, fittingness, and auditability were established. The findings were trustworthy, since individuals having similar experiences were able to recognize personal experiences in the descriptions and stories told by the researcher.

Ethical Considerations

Ethical Review

This study was approved after submission to the Faculty of Education Ethics Review Committee, University of Alberta. Endorsement was also obtained from the aforementioned Edmonton youth agency and approved by their Board of Directors.

Informed Consent

Prior to commencement of the interviews, the participants were advised of the purpose of the study, the length and amount of participation required, the strategies for anonymity, benefits, and any foreseeable risks to participating in the study. They were asked to sign an informed consent form (Appendix C) before beginning the first interview and reminded that they could withdraw from the study at any time without explanation. Ten youth had previously signed release forms with Child Welfare, giving them complete independence from their parents; thus parental consent was not an issue. The two pilot interviewees obtained consent forms from their parents (Appendix D), in addition to signing personal consent forms themselves.

Confidentiality and Anonymity

Strategies to recognize and ensure anonymity and the rights of the participants who agreed to become involved with this research study were undertaken. Confidentiality could not be ensured because the nature of qualitative data requires that direct, potentially identifiable quotations be used to add depth to the written report of the study. The participants were made aware that interview data might be used for teaching purposes, but that anonymity would be ensured. Anonymity was protected when participants' names and demographic information were removed from all tape recordings, written transcripts, and fieldnotes and replaced with randomly assigned pseudonyms known only to the researcher. Only the researcher, thesis supervisor, and transcriber had access to the raw interview data. These individuals agreed that the information concerning participants would be kept confidential. Transcriptions, audiotapes, and the assigned coding information were kept in a locked filing cabinet for use in future studies subject to ethical review. Informed consent forms were kept separate from the transcripts. After a period of seven years all data will be destroyed.

Risks and Benefits

It has been previously noted that although information forms were given out by the program director/outreach/case workers, the perceived power over the youths in no way interfered with the consent procedure. Neither the Director nor case/outreach workers are or have been privilege to information regarding the names or experiences of the participants. The study was conducted only with the full cooperation of the youth agency staff so that coercion was not a factor in the decision to participate in the study.

There were no risks to participating in this study, and no incentives were used to elicit participation. The names of healthcare workers and appropriate counselors were made available to the participants in case of physical need and/or emotional distress. Contact names and numbers of health care workers at the Birth Control Centre and STD Clinic were identified in the event the participants required future services or information. It is the researcher's intent to make summary copies of the final report available to all participants in the study. The researcher will submit the results of the study for publication in relevant health journals and will present the findings of the study at relevant conferences.

Although there were no tangible benefits to participating, the study gave participants a chance to help others understand their experiences and the opportunity to generate further knowledge of adolescent sexuality. Some participants have described gaining a new perspective about their situations and found the interviews to be an empowering and healing experience (Morse & Field, 1995).

The findings of the study are presented in the following chapter. The adolescents' own words were used as much as possible. Repeated interjections, such as "um," "you know," and "like" were deleted from the transcript excerpts when they interrupted the flow of the quote and were not vital to the meaning of the statement.

CHAPTER IV

FINDINGS

The initial research question proposed for this study was, "What are adolescent's perceptions of the key elements of sexual behaviour and sexual risk?" In the process of designing the interview protocol, a variety of topics were included which addressed both adolescent sexual behaviour and adolescent sexual risk. The process of engaging the teens in meaningful dialogue was deemed more important than forcing their responses to conform to a rigid interview protocol. While completing the interviews, sub-questions were asked which included: How does previous sexual experience impact on sexual activity? What are adolescent impressions of sexual health education? How do adolescents define risk behaviour and how do these behaviours impact their lives?

The first part of this chapter includes a brief overview of the adolescents who participated in this study. A more thorough understanding of the adolescents' perspectives can be gained from additional demographic knowledge of these unique individuals' backgrounds. A more complete description of these teens is found in Appendix E. Following this, the data collected during the interviewing are presented in accordance with the themes and categories derived from the transcripts. The adolescents' descriptions of the variety of factors influencing their thoughts and behaviors are illustrated using excerpts from the interview transcripts. Participants are identified by pseudonyms known only to the researcher.

Participant Characteristics

Ten participants between the ages of 15 and 19 were interviewed for this study; four were female and six were male. The 10 youths were recruited through a youth-oriented independent living program in a Northern Alberta urban youth agency. The major portion of the literature review focused mainly on average, middle-class youth and the advantages inherent to this income level. These advantages typically included a combination of the following: higher socioeconomic status, improved education, extracurricular activities, and a network of support systems. The adolescents from the youth agency have all been through numerous life changes and have endured incredibly unstable living conditions as outlined in the following paragraphs.

Family Background

Many of the teens interviewed came from single-parent homes. Most of them had been through divorce at some time during their childhood, and others had never met their fathers. Four male teens had been excluded from their homes due to behavioral problems. Three of the girls interviewed left home once they found out they were pregnant or after they had given birth. Most of the teens voluntarily left their homes because of conflict with one or both parents, and others left due to general family dysfunction. Two males had spent time in jail, and one participant in particular had changed living conditions over 10 times in the past three years. A complete description of the family living conditions as well as participants' demographic information can be found in Appendices E and F.

Everyone interviewed lived independently, facilitated by the independent living program. Most adolescents reported improved relations with their families since moving out on their own. Only three participants were no longer on speaking terms with their immediate families.

School Background/Future Goals

The participants were asked to describe their enrollment in formal education. Only two interviewees were currently attending formal education classes. These two participants were young females who had recently given birth and were either just re-entering school or sporadically taking courses in hopes of eventually receiving their high school diplomas. Five participants had university/college aspirations, three youth intended to receive their high school diplomas, and two did not care one way or the other.

The participants were asked to describe where they thought they would be 10 years from today. This question stimulated responses about occupational aspirations, and all answers reflected the future career paths of the sample. The variety of occupational goals can be found in Appendix E. Six of the informants currently held a paying job, and most had an idea of the occupation they wished to pursue in the future.

Extracurricular Activities

The participants described a range of free-time activities, including fitness training, movies, music, and hanging out with friends. Many of the youth interviewed, when asked how they spent their spare time, responded with interests in writing, poetry, and listening to music before more stereotypical extracurricular activities such as hanging out or visiting the mall.

Sexual Activity

Of the 12 participants interviewed, 10 adolescents reported having engaged in previous sexual intercourse. One female and one male respondent reported no activity at present or in the past but were unable to articulate their stance on the subject effectively. Of the participants who had previously engaged in sexual intercourse:

- Two males reported having intercourse at age 13
- One female and one male at age 14
- One male at age 15
- One female at age 16
- One female at age 17
- One male at age 18

The average age at initiation of sexual intercourse was 15 years: 14.8 for males and 15.3 for females. Further probing revealed that the average number of partners that each participant had had was approximately 3, but one male respondent had had upwards of 25 partners in his short sexual history.

Songs and Sitcoms

In an effort to discover more personal information about the sample, the following question was posed, "Can you think of a movie, sitcom, or song that describes your life?" Although most could not readily think of anything off the top of their heads, those who responded genuinely had a connection with the items mentioned. Kelty was the only one to choose a television show, but when asked the question, she emphatically said that *The Roseanne Show* completely fit her home-life experiences: "Mouthy kids, fighting all the time, angry parents, pretty much it" (Kelty: 85). Kent felt that rap music best described his life on the streets and his involvement with gang activity. The songs he selected were generally angry in tone and spoke of the violence that in his experience had led to power and respect. Kevin's theme song was titled *Under the Bridge* by the Red Hot Chili Peppers. "It feels like there is no one there and you have to do it all by yourself. It just makes sense to me" (Kevin: 53). Kyle found Pink Floyd's *Echoes* to have a calming effect on his life. This instrumental song begins calmly then escalates into a climax of sound before returning to a more peaceful conclusion. In Kyle's opinion, life mimics a series of noises and climaxes dispersed between periods of calm:

> You know the sound of a submarine? It starts like that, and then a little bit of music comes in slowly. Then echoes in the water, and they perform themselves into music. . . . And it goes off like this in the shape of a mountain. It starts off calm and works its way gradually up to the peak, of music. . . . It eventually calms down and makes its way back to the sonar pulses again. There's something about that song. . . . I'd really like to know how it applies to my life. (Kyle: 167)

Katy chose *Around Here* by Counting Crows because she said that it was a song about the process of finding oneself during an often-tiring lifelong search: "Round here we're carving out our names, / Round here we all look the same, / Round here we talk just like lions, / But we sacrifice like lambs. / Round here is slipping through my hands" (Adam Duritz, *Counting Crows,* 1993).

Healthy Behavior

After the participants were asked a variety of questions designed to elicit background information to ease them into the interviewing process, the issue of health and the concept of healthy behaviors was addressed: What does health look like? The first question asked the adolescents to describe what "health" looked like to them. A few questions were asked to elicit participant's ideas of health in general. Responses to this question fell into two main themes: physical health and complete health. The topic of sexual health was not addressed by the participants at this time.

Physical Health

This category included responses that comprised eating or nutrition, adequate exercise, limited substance use, and good sleeping habits. Six respondents (three females and three males) identified nutrition as a key component to "health." Comments included references to both quality and quantity of food intake. All but two participants named exercise as vital to a healthy lifestyle. Activities included walking, weight training, Tai Chi, aerobics, and team sports. Four males and one female emphasized the effect of substance use on their health. All agreed that cigarette smoking, excessive alcohol use, and drug habits (marijuana, acid, etc.) were barriers to overall good health. Karen focused on the importance of sleep and rest to the body, and Kent mentioned personal hygiene as something that was of particular significance to him. Karl however, chose a classic dictionary definition to give his opinion of health as being "free from disease and whatnot." Other comments included the following:

> Just basically you've got to take care of yourself, you've got to watch what you eat. You shouldn't smoke, but I do it anyway. I don't know, just maintain your exercise and whatnot, make sure you're working your body out so that you stay in shape. Eat the right food, that kind of stuff. (Kelty: 89)

> I like to keep physically fit and stay focused on my physical abilities because of my job; I have to be in shape. I do drink and smoke, but I'm quitting smoking because I know its not good for you. But my physical fitness is important to me, so I try to stay in shape. (Kurt: 51)

> I'm trying to kick drugs, not really eating much and smoking. I've been missing a lot of training. I'm still fit, but I'm not healthy. (Kevin: 69)

Complete or Overall Health

This category included all comments that described health as an inside/out or mental/emotional state of well being. Four participants (three male, one female) had an opinion similar to Keith's when he spoke of health as a state of mind: "Well, feeling good I guess"(Keith: 17). Kyle, Katy, and Kevin saw health as something more than the things put into their bodies, but also what their bodies can produce. All mentioned the need to work from the "inside out"(Kyle: 189). Katy outlined how mental health plays a factor in physical health:

> I think healthy isn't just mind or body; it's both, because if you're really depressed, you're really unstable, and your mind is really confused and really out of control with how to deal with what you don't understand about life. Then it affects your body too. (Katy: 315)

Both Kyle and Katy felt that health could play a role in building self-esteem and self-confidence and vice versa:

> I know that I can accomplish things. I have a little more self-confidence, when I go into a more structured class or just kind of instruction, I can apply myself way better. So that is health for me. (Kyle: 226)

> It's not healthy to think that you are a piece of shit because you don't look perfect; it's not healthy to starve yourself because you don't. It's not healthy to do all the things that you do. And then the thing is, I did that, I did that so bad. I mean, I wasn't anorexic or nothing, and I wasn't bulimic, but I got so depressed and so whatever with just life in general, and then the fact that I thought I needed the perfect body too. (Katy: 329)

Kyle and Kevin both concluded that although some people seem "born naturally more healthy than others," they felt that consistent overall health depends on constant attention and hard work: "You've got to keep your body moving, you've got to keep—it's like momentum. If you want to be healthy, you've got to remain healthy" (Kyle: 202).

Incidentally, when asked whether they would classify themselves as healthy, seven participants (five female, two male) said 'yes,' where four males, for the reasons indicated, did not think that they were healthy at the time of the interview.

Common Adolescent Behaviors

To gain an informed perspective on how adolescents view the world around them, they were asked some questions about the status of adolescent behaviors in some commonly attributed situations (see Table 1).

Table 1

Frequency of Common Adolescent Behaviors

Behaviors	Participants saying yes	Participants saying no	Range
Smoking	10	2	3-17 (or 1 pack)/day
Drug use	5	7	Experimentation - often
Alcohol use	9	*3	2/month-2X/week

* One girl who was pregnant said that she no longer drank since finding out she was pregnant.

Smoking

When asked, “How many teens today smoke cigarettes?” the teens responded with a range of 40% to 90% (mean, 65%) smoking by the time they reach age 20. Comments on the subject included “most of us,” “a really high amount,” and “shit, a lot.” Experimentation begins early in Grade 7 (12 to 13 years). The participants supposed that regular use occurred by Grade 9 (14 to 15 years), but agreed that if teens had not started by junior high, then they might not until they turned 18. Males started because “it looks cool,” whereas females succumb to “peer pressure.” Karen brought up the increasing use of chewing tobacco among male students. Sadly, cigarettes are easy to obtain, whether from older friends or siblings or simply buying packs from other “suppliers.”

Drugs

When asked, “How many teens today use drugs?” a range of 35% to 90% (mean, 65%) was reported. Comments on this subject included, “All people talk about [drugs] in the halls at school,” and “everybody I know does drugs, almost.” The most popular drug in this age group was marijuana, followed closely by acid and cocaine. These teens were of the opinion that most people use them once in a while, but that the most frequent experimenters eventually become regular users. It was thought that most teens by the time they have turned 16 years have experimented with at least one kind of drug.

Alcohol

When asked, “How many teens today drink alcohol?” a range of 50% to 80% (mean, 71%) was reported. Comments on alcohol use included “not so many before Grade 10, then everyone,” and “As soon as you turn 18 it is nonstop.” Alcohol is very much a part of high school life. Once teens establish a social life, parties are common, and alcohol flows freely at most weekend engagements. This, of course, depends on their group of friends, but alcohol is very much a factor during this time.

Sexual Experience

When asked, "How many teens today are having sex?" a range of 50% to 90% (mean, 77%) was reported. A frequently voiced comment was that "most sexual activity starts in high school." Most of the participants supported this comment and said that many teens today have had sex by the time they turned 16 years: "A big boom once you hit high school." It is almost assured today that by the time teens leave high school, they will have had sexual intercourse. A complete description of the sexual experiences of these adolescents can be found in Appendix G.

Friends

Although direct questions on this subject were not asked, the "friend" role in adolescent sexual behavior emerged on numerous occasions. Friends in this case could refer to anyone in the teen's immediate circle of peers or those individuals termed *best friends* who are closest to the respondent. The subject of friends became a central theme when speaking about contraceptive use and sexual health education sources. It was significant to outline the roles that friends play in the lives of adolescents, as separate from their roles during key decision-making opportunities. Comments on the importance of friends could be classified into two categories: comparison and influence.

Comparison to Friend's Behaviour

Those responses that fell under the category of comparison spoke of the self and his/her behavior in comparison with that of a close friend. This information can further be used to justify the friendship in the first place. The teens shared both positive and negative experiences with friends:

> Friends are a big help, especially the ones that know what's going on. . . . We always swap stories and what we know, and it helps a lot. People who are at the same stage know and can relate. (Karen: 524)

> No, most of them [friends] don't differ from me. That's why they are my friends. (Kevin: 301)

Friends are chosen based on comparable characteristics. Friends can relate to each other because of similar experience or attitudes. Kevin alluded to a likeness in behavior that provides the groundwork for meaningful friendships. This also explains how friendship can evolve or change in certain circumstances. Kelly had a negative experience after she became pregnant and subsequently gave birth to her daughter. She found that because her life had changed so dramatically, her former group of friends did not have much in common with her any more; thus, they ceased to "hang out together."

The participants interviewed in this research study also noticed a difference in gender attitudes towards the usefulness of friends when it came to talking about sex. Girls were more likely to mention discussing sex in detail with some frequency, whereas the males kept to themselves until events unfolded which required sharing:

> Girls pretty much enjoyed talking about it, especially if they've experienced it. Honestly, we talk about it all the time. [We talk about] penis size and bisexuality; we talk about that a lot. (Kelty: 764)

> I mean, we all pretty much keep to ourselves, because it's really no one else's business. But he doesn't concern himself with my sex life. It's none of – he knows it's none of his business, and he doesn't care if I am having sex or not, to tell you the truth. But we all, I mean if we say that we've had sex with a new partner…(Kurt: 352).

Influence of Friends

Influence was the second most common theme emerging from the dialogue on friends. Most of the adolescents interviewed admitted to looking primarily to their peers when they had questions or needed information on sexual behavior. Ultimately, the teens realized that "it's my decision in the end"(Karl: 553).

It would not be uncommon to go to a secondary if not a more reliable source of information. Influence within a group of teens also depends on the groups' inner structure. As with any collective of individuals, there are leaders and there are followers. Leaders set the example, whereas followers take their cue from those perceived to be "in charge." The degree to which one can be influenced as well as the behavior itself depends on where one falls in the chain of command:

> They're just friends, support. I don't think they influence me really. I'm more the one they look up to. I'm just, . . . I like taking on the leader role, being the one to look up to. (Kevin: 352)

There should be no mistaking the power of one's circle of friends. Especially during adolescence, friends have the potential to be the most influential factor in a teen's life as illustrated by the following quotations.

> When you are a teenager, whether it be—well, maybe not as much my age [18], but a little younger than myself, in your eyes, your friends are everybody. Outside your circle of friends, nobody else exists. But in general just your clique is everybody. So if something happens to somebody outside your circle of friends, you're not going to be too concerned with it, because it doesn't involve anybody that is your friend, anybody that you care for or care about. (Kelty: 578)

> Your friends definitely have to tell you what's up and why. You see, my friends are very open and they'll tell you what; that's why they are such good friends, because of the way they are honest about things. They'll tell me what they think about what I'm doing, and that's important, you know. (Kurt: 517)

Defining Sexual Behavior

> Sexual behavior I think it would be like; it's a spectrum, sexual behavior. (Kyle: 399)
>
> Anything included. Well, sex itself, intercourse is just sex. But there is other stuff. I don't know how to put it nicely, blowjobs and stuff like that; I don't consider that sex. That is one of the steps leading up to it. (Karen: 317)

Activities, which are deemed sexual behaviors are contingent on many factors. The responses to this probe can be broken down into two themes: what are sexual behaviours and what should sexual behaviour include. *Harmless activity* and *arousal/stimulation* were categories of the first theme while *becoming emotional* and *intimacy* were features of the second theme.

Harmless Activity

Most respondents felt that kissing could be excluded from the definition of sexual behavior because this act is common and casual, and "you can't get any harm out of a kiss" (Kelty: 151). Six participants said that anything beyond kissing had the potential to become sexual. Thus, those who felt a behaviour was harmless consequently did not feel the behaviour was sexual. Consensus among the participants was that one could kiss parents, friends, and so on; but sexual behaviors somehow go deeper. For example:

> I don't know. It's anything; not kissing and above, like above kissing, I suppose. (Karl: 142)
>
> Doesn't necessarily mean having sex, having intercourse, but sexual behavior, a lot of things could fall under that: oral sex, stuff like that. Something that doesn't involve penetration, I'd still consider sexual behavior. Well, if you kiss a guy, that's not sexual behavior necessarily; it's just a kiss. You can't get any harm out of a kiss. (Kelty: 146)
>
> I think it's when you get past that [kissing] with touching and caressing. Once you get past that stage then it's probably sexual. You can kiss your friend and whatever, and that's not sexual at all. But if you go deeper, I think it is. (Kevin: 118)

Arousal/Stimulation

This feature of sexual behavior is attributed mainly to and by the males. The youth in this study reported that once a person reached a certain stage (usually touching or petting), hormones kick in, and the activity moves into something more sexual:

> And even to have your ass slapped isn't really sexual; but I mean, it's playful, right? But once you get past that it becomes sexual, because then it starts a little more hormonal stuff there. And especially for a guy, he gets past that, and then it's definitely sexual, I think, for a guy. (Katy: 427)
>
> Like when they—mostly kissing or touching like that, and it turns [guys] on. (Karen: 74)
>
> I think there's stimulation involved. (Kent: 258)

Becoming Emotional

A few adolescents identified sexual behaviors as those which occur when one made an emotional commitment to a partner. This is not the same as a casual, spontaneous encounter but occurs because of a closeness or a bond between both partners:

> I mean, I think there should be some emotion involved. I'm not saying you don't have [sex]. And I think you should—you know, sexual behavior is just having sex, period. I mean, if you're not [emotionally involved], it could be anything. It could be anything from just making out to having intercourse or whatever. (Kurt: 129)
>
> [He] and I are like so intense and serious; there is no other. Our worlds are completely just us, and I am nothing without him. It's like I am completely in love with him. Completely in love. (Karen: 237)

Ensuring Intimacy/Privacy

Respondents suggested that sexual behaviors should be private acts between two people and could not include anything that one might do before a crowd of onlookers.

Sexual behavior implies some sort of shared moment between two people and is not casual or publicly displayed.

> If you were having a relationship that's sexual, it would be something else more intimate than just holding hands. (Kelly: 105)

> Yeah, it's more private. You can't just go out and take off your clothes and just, "Let's go baby!" right in a stairwell. (Kent: 267)

In addition to a definition of sexual behavior, the concept of abstinence was discussed to obtain the teens' reactions. The most common response, nine participants agreed, was that abstinence was unrealistic:

> But I mean abstinence isn't a reality, because the majority of people out there are having sex, and even the people that don't want to, I mean, that aren't having it, they want to. (Kurt: 333)

Three responders, two females and one male, felt that it would be better for teens to wait until they are more responsible and mature. Karen asserted that sexual relations should be "saved until marriage."

Sexual Experiences

The best way to present these data is to do so in four sections. The first section reveals the individual responses of a few of the most articulate participants in this sample. This provides an opportunity to present the many factors that were identified as influencing adolescent decision making with regards to sexual intercourse. The second and third sections present the composite findings for the context of first-time sexual engagements and for the emotions that the teens encounter as they begin a sexual relationship. Finally, in the fourth section are the reasons that youth provide for abstaining from sex in the past.

For example, Katy's first experience with sexual intercourse was a one-night stand with an older boy she had met after a night on the town with a girlfriend. Both girls went back to the boy's house for drinks and a movie but the girls instinctively knew that more would happen that night. In retrospect, Katy knew that she had made a mistake by having intercourse with someone she barely knew:

> But it turns out later he's one of the worst guys to have, you know, been my first. But too late, what can you do? . . . And you can't change it. That's the worst, is you can't change it. I wish more people understood that. (Katy: 504)

Katy mentioned that alcohol and curiosity played a substantial role in the events of the evening. She felt that everybody she knew had had sexual intercourse and that somehow she was being left out of her friends' activities and conversation. Her lasting regret was that "I didn't really take into consideration what would be taken away from me" (Katy: 455). This casual type of sexual encounter left Katy with an emptiness that led her to believe that sex was something that she could do to show her partner her feelings. Eventually, Katy reported that she tried to please her boyfriend by allowing him to have intercourse without a condom. At the time of the interview Katy was just entering her ninth month of pregnancy. To this day she claimed she never had a pleasant sexual experience. To her sexuality is like "a special, secret part of you that gets invaded. It's like someone going into your deepest, dark closet of secrets and allowing somebody to know ten of them every time" (Katy: 1005).

Kent lost his virginity to a girlfriend who he had been dating for a short while. He remembers having to wait to have sex with her for the first time. For Kent the experience was less then perfect because although he thought the act would be self-explanatory, he had some trouble figuring out how everything "worked."

> And, oh, I tried to make it look like I knew what I was doing, but I really didn't my first time. I was thinking, she's going to think I don't know what I'm doing. . . . But she looked like she was also scared, and then I thought it was funny. (Kent: 342)

Kent now felt that each relationship was an experiment and that he learned more about sex with every new partner. He recognized that it was a big relief to put his "first time" behind him and move on with his sexually experienced friends.

On New Year's Eve when he was only 14, Kyle lost his virginity to an older girl with whom he had been hanging out for a couple of years. Stealing an extra key to a separate house his mother owned, he invited a few friends over for a party. All the youths had indulged in considerable amounts of alcohol and marijuana, when Kyle's girlfriend invited him to take a shower with her. He was quite surprised by how forward she was about sex, because he had not expected to be having sex that night. Kyle described his first experience as "really awkward for me. I was very, embarrassed, you know. I was all blushing and everything; and I don't know, it wasn't like the greatest experience in my life" (Kyle: 566). Kyle was actually quite disappointed with his "first time." Kyle reported that it was a couple of years later when he met a companion with whom he enjoyed having sex in a caring and committed relationship. To this day he remembered his first time with some lamentation:

> It was just, actually, it took away from all the anticipation I had. I thought sex was going to be so wonderful. I was really looking forward to it. Oh, man! I figured I'd just like explode with just joy and just great emotion. Wow! This is the most wonderful experience of my life! It wasn't. (Kyle: 579)

Kelty reported how she was motivated to lose her virginity. "This sounds really stupid, and I know it's very stupid. My sister lost her virginity two days before I did, and I didn't want her to be sexually active and not have me be sexually active because I just didn't think it was fair" (Kelty: 162). The circumstances of this union were somewhat different from the others previously mentioned. Kelty had been dating her boyfriend, also a virgin, for over a year when they decided to have intercourse. She described being "very, very nervous; extremely nervous" that night. Kelty was allowed to have her boyfriend sleep over and was even provided with condoms by her mother. She remembered feeling protected both from pregnancy and disease, as well as from outside influences. Her overriding memory, however, was one of intense pain from intercourse. A year later during a night of drunken partying, Kelty and her current boyfriend would sleep together without using a condom and she would become pregnant at age 15.

Karen was the only female to wait until she was 17 to have sexual intercourse. Karen said that she waited so long "because of AIDS, diseases, and guys that leave you after they get it. People lose respect for you and all that stuff" (Karen: 229). She was also one of the few youths interviewed who waited for sex until meeting the person who she believed she would one day marry. She had been dating her boyfriend for seven months before initiating intercourse. "I probably would have waited longer, but [he] and I are so intense and serious; there is no other. Our worlds our completely just us, and I am nothing without him" (Karen: 237). Karen said that she was able to wait so long because she and her partner had built up to the moment by doing many other sexual acts but saved intercourse for a time when they were both ready for the responsibility. The couple rented a hotel room for Valentine's Day and had a picture-perfect evening. Karen had no regrets about giving up her virginity in this manner and wished that others would wait because the right time will eventually appear.

The youth with the longest history of abstinence in this sample was 18 when he lost his virginity. Kurt wanted his first time to be special, and to him that meant waiting for the right person with whom to become intimate. All his life he had kept himself busy with other activities and was not concerned with missing out on sex and serious relationships. When he eventually did meet the "right girl," they discussed sex and even bought condoms in anticipation of the "right time." "It was pretty spontaneous. I was in a relationship with someone that I cared about a lot, so it was a serious step in the relationship, so it had a lot of meaning, for me anyway" (Kurt: 165). Kurt described the experience as "fooling around, and one thing led to another." Although Kurt felt that he had waited for the "right circumstances," he sometimes thought that maybe he should have saved himself for marriage. Because he had had sex once, he felt obliged to have sex in every relationship and found that most times the experience ended in hurt feelings and diminished the pleasure one should receive from an act of love.

Context

What can be learned from these stories of first sexual experience? One begins to see something of the nature of the relationships when the teens had first-time sex. Whereas some adolescents reported dating for a "little while," others admitted having known their partner for "only a week" or having "just met that night." A couple of the participants had serious boy/girlfriends who had dated monogamously for up to three years before initiating sex. Partners ranged in age from the same grade to many years older. Substance use can factor heavily in adolescent sexual experiences. Three of the ten youth interviewed reported alcohol use preceding their "first time," and two admitted being stoned or high from marijuana.

Where do these encounters take place? Most of the first-time acts described took place in either the girl's or guy's house. Many of the teens had sex during school hours when the parents were not at home or after hours when most parents had gone to bed. In some cases sex occurred during an allowed sleepover with one's partner. In one case, Keith described sneaking up to the girl's floor of a youth shelter to have sex with his girlfriend. Karen and her boyfriend stayed in a hotel room to celebrate their "first time."

Who was present at these events? As mentioned previously, parents were often upstairs or down the hall from the young couples. In many cases the teens were at a party when the couple broke away from the crowd to have sex. Often a friend was present initially but then left when the couples wanted to be alone. Only three of the youths interviewed reported being completely alone for their "first time."

Emotional Reactions

What were the quoted reactions to having sex for the first time? Two participants (one male, one female) used the word *horrible* to describe their first experience with sexual intercourse. Other descriptors included *stupid, lousy, painful, scary, nerve-wracking, embarrassing,* and *good.* Many thoughts were articulated on their feelings towards losing their virginity. "I didn't know what I wanted," "I felt like I was ready," "I didn't know what I was doing," "I knew it would not be anything that special," and "I wish girls would think about what they are getting into" were just a few of the comments made during the interviews. From the youth interviewed , the overall impression of their first time was negative. Only a couple of the participants enjoyed their experience, whereas the majority were simply relieved to put the act in the past.

The teens illustrated their reasoning for having sex as being "curious," "we both wanted to go all the way," "the opportunity was available," and "it was the right time to do it." In a related question the teens were asked to comment on why they had not had sex in the past or their reasons for abstaining in the past. These replies were broken into four categories.

Waiting for the right person. Six of 11 respondents had wanted to wait for the right person. Four males and two females wanted to feel comfortable with their partners because they did not want to lose their virginity to "just anybody." Some youth talked about not having sex again until they met the right person to avoid making the same mistakes twice:

> Yeah, I'm waiting for her. I figured if I'm going to experience that, I don't want it just to be a sexual thing. I want a meaningful—I want to actually know what love is about. I want to see the very depths. (Kyle: 605)

> I didn't do anything with them [other boyfriends]. I kissed, that's all. I wasn't interested in doing anything. I wanted to save everything for somebody that would be special. (Karen: 298)

Doesn't feel right/not ready yet. Teens in this category felt that they were too shy or scared to go through with the act of intercourse. When asked what *ready* meant, the youth could not articulate an exact meaning but described more of a feeling that the time was right:

> But the other nights were different. I don't know what was different from the other nights, though that night I did lose my virginity. I mean, it was totally the same. I was still scared; I was still very nervous, but I went ahead with it anyway. (Kelty: 223)

> I don't know. It's just sometimes with people around or if you've got a lot on your mind. Sometimes it just doesn't feel right; it's just not right for them. (Kevin: 186)

Not interested in sex. Some of the teens interviewed said that other interests preoccupied their time and felt that they were late bloomers when it came to experimenting with sexual behaviors. They waited to have sex because it was not something that they had thought about doing; thus it was not an issue in the past:

> I never thought much about it because I had never known what it was like. I wasn't curious, to tell you the truth; I wasn't really into it. I was more into my hobbies and stuff, so I never really paid much attention. (Kurt: 323)

Wrong circumstances. This included comments about too many people present or an improper atmosphere. "It wasn't convenient, there was somebody home," or "there was too many people around."

Against their religion. Although no one in this sample abstained from sex due to a religious belief, many had friends who were still virgins because of the beliefs of their church and families.

Distinguishing Between Sex and Relationships

Another theme which emerged was the notion of sex and relationships. A distinction was made between the two, and one did not necessary result from the other.

Karen spoke about the important qualities in a relationship: "You need to know how to treat each other," "be respectful," and "have open lines of communication." She said when you have these ingredients you can talk to your partner about things like sex and contraceptive use. Kyle said that guys and girls have different viewpoints when it comes to relationships. Guys are looking for "quantity" and to "get as much as they can," whereas girls are focused on "romance":

> [Guys] want to get as much as they can in as little time possible. And girls, they want a long-lasting, beautiful relationship with flowers and daisies and a white picket fence, that kind of thing. (Kyle: 313)

With regards to sex, Kyle believed that a teen sexual relationship was one of "discovery" where "flirtatiousness" is used as a means to test "compatibility":

> Concerning sex and how people think sexually, a lot of it's very carnal almost. You have desire, and as soon as you know what sex is about, you imagine yourself having sex. (Kyle: 497)

Kelty focused on the interplay between sex and relationships. She felt that "sex puts stress on the relationship." She commented that having sex at a young age caused a premature state of maturity that most teens were not ready to accept. "And the maturity that you're going to have to gain. If you're sexually active you have to be mature enough to be able to talk to your partner about it." Kelty indicated that sexual patterns of behavior are perpetuated in future relationships. Past experience plus the desires of your new partner equals pressure to have sex again. She did not like the expectation of sex which is both assumed and self-inflicted in new relationships. But she felt that it is inevitable once you start having sexual intercourse:

> Well, you get into a relationship; you have sex for the first time, whatever; it's all good, it's fine. You move on to another relationship, and you feel the pressure:

> Well, okay, I've had sex. I had sex with my last boyfriend, so that means I have to have sex with this one too. And then you keep going down the line. (Kelty: 803)

Kevin felt that the relationship itself should carry some weight before sex is introduced as an issue: "Before anything, I want to be able to talk to the person." Like Karen, Kevin valued communication in a relationship and sex as simply an add-on to an already good thing. "Like, I want to get laid, but who cares? [Sex] has got to be there, but it's not a big part, no." Kevin let his romantic side show when he said, "I still think there's a certain person for everybody, but what are the chances of finding them with millions of people in the world?"

"Relationships should be like the guy on *Star Trek Voyager*. People should link, share a mind-meld kind of thing." Kent's description of a real relationship is one where both partners share their thoughts and feelings and activities with each other. He felt that a good relationship can be an esteem builder:

> It just, all of a sudden I had a girlfriend now. In the past, all those other times I didn't have nobody. And it was like I had my TV, but that was about it. So then finally I got out more and this and that, and started making friends instead of being all quiet in the corner. (Kent: 376)

Kent saw sex in the relationship as a "present we are willing to give and receive." If both partners are in the relationship for the right reasons, then the anticipation of sex can be exciting and the actual act of sex exhilarating. Katy had had negative experiences with both sex and relationships. She viewed her involvement in relationships as a "need for affection" but noted that her previous relationships had been unhealthy because she was so busy "trying to please" her partner that she had lost her sense of self:

> I don't know. It gets built into your mind that you need this affection or something. But sometimes . . . I'm looking for somebody to hold you, somebody to care, and somebody to be there. It just becomes like almost an overwhelming thing, and you want that so bad that you're willing to go out that night and just be with somebody. (Katy: 532)

Sex for Katy carried negative connotations because she felt "embarrassed" and "nervous" and was "afraid to say no." Because she was unsure how to conduct herself with her partner, she had the attitude that somehow "actions are louder than words." Thus, she came away with the idea that sex is "overrated."

> There you go; because they don't—love is nothing. Sex and love, they're two different things. They're two different things all the way, and most people that get into sex are looking for love, not sex, and love has nothing to do with it. (Katy: 1018)

Kurt spoke at length about relationships and sex. He said that he truly believed in the value of "commitment" to a partner before proceeding further in the relationship and not in jumping from one relationship to another: "If I'm not going to be in love, not going to be totally—give myself to somebody one hundred percent, I'm not even going to bother with a relationship in the first place; there's no point" (Kurt: 601). Also, Kurt believed that one must establish an "emotional attachment" to a partner before one can feel "comfortable" having sex with him or her. Having introduced sex once into a relationship, more "pressure" and "responsibility" is added. With regards to sex, Kurt felt that if one was in a relationship and "attracted" to a partner, sex was inevitable, especially if there had been sex in a relationship before. As with Katy and Kelty, Kurt noted that prior sexual experience seemed to dictate actions in subsequent relationships. Emotions were also noted in sexual relationships:

> I'm sure there can be emotion involved without [sex], but I really can't see getting to that level, that really, really deep level of emotion, without sex. I mean, there can be that caring and stuff, but I can't see it not being as intensely emotional without sex. (Kurt: 638)

Contraception

Contraception emerged as a theme in this study. Five sub-themes emerged within it.

Protecting Myself

Most of the teens interviewed realized the importance of using condoms during all sexual encounters. A few commented that condoms have become more "cool" because of how they are presented in the media:

> And, well, TV and movies, it's real big. I remember seeing movies, girls tearing condoms with their teeth and in the heat of passion, and there's no hindrance from it. (Kyle: 820)

Some adolescents feel that the number one priority must be self-protection. Teens, however, said that they get caught up in other issues when faced with the possibility of sex. This is where judgment breaks down, resulting in a variety of negative outcomes (pregnancy, disease, and emotional anxiety): "[If] you take chances, then you end up with pregnant people that weren't even ready for sex in the beginning, but now they're going to have a baby" (Katy: 517).

Most respondents in this study acknowledged the importance of condoms in sexual relationships, yet noted a decline in condom use once they had been with a partner for a period of time:

> And that is the thing too, I think, when you're young like that. Whether you don't think about [condoms] as important, or else you do think it's important, and after the first couple of times, you don't think of it as important, and that's sad too. (Katy: 514)

> And I use protection, and I'm—not all the time, but the first times and many times after that. (Kurt: 359)

> I insisted on [condoms]. Wish I would have done that a couple years down the road. But I insisted on it the first time and numerous other times. So I did have safe sex the first time. (Kelty: 186)

Furthermore, some respondents reported that they protected themselves at all times and hoped to keep it that way in the future: "Either you use a condom or you don't, or you don't have sex" (Kelly: 240).

> See, two times I did it without a condom. But, nowadays it's like, you use condoms all the time. You don't want to get AIDS and die. I won't do anything until I get a condom. (Kent: 402)

Taking Chances

Many of the adolescents interviewed were knowledgeable about why condoms should be used and how to use them. They outlined the barriers to use and where the breakdown between knowledge and behavior occurs. Some teens carried an "It won't happen to me mentality," and others were "not really worried about it at the moment." Still others said, "I knew that I was clean and she was clean, and you don't really think about pregnancy when you are [young]." Keith explained why he did not use condoms: "I know it's not safe; it's just the way it happens" (297). A common perception was that the condom detracts from the momentum of the moment.

> You felt like continuing an activity, but if you were to say, "Do you have a condom?" and they were to say no, then that's the end of that. (Karl: 408)

> I know that in the heat of the moment, I guess the passion that is going on right then, it's moving, it's momentumizing. And then the condom package is a hundred-foot brick wall all of the time. (Kyle: 856)

The most often reported reason for lack or discontinuation of condom use was that the couples did not like the lost sensation that they experienced when they used condoms. Two males and one female respondent voiced this opinion during the course of the interview:

> I don't think anything else will work for [a friend]. She just, she doesn't like using condoms; she doesn't like the way they feel. (Kelty: 604)

> Probably—well, the feeling was the most of all; we wanted to have that feeling. And we, we were, I guess we just, you know, cared about each other enough to, I mean, let it happen. (Kurt: 238)

> It still felt pretty good. But it wasn't the spectacular experience I was expecting once again, you know. And then this one time—I can't say when—I just didn't, we just didn't use a condom. I was like after that, we used a condom once maybe, and then, then we didn't, and oh, uh, it was really good. But we're playing with something in life; we're playing with creation. I don't really think I have quite the experience to be able to handle it. It worries me. (Kyle: 654)

Initiating Responsibility

The responsibility for who initiated safe sex depended strictly on which gender answered the question. Four respondents spoke of the pressures of safe-sex initiation. Both female respondents said that the responsibility almost always lies with the female partner: "Guys just want to get in there and get it wet, and blah, you know, whatever. I think it's mostly the girls that initiate the safe sex. Occasionally it's the guys, but most of the time it's the girl" (Kelty: 612). Both male respondents said that it was up to the guy to supply the condoms:

> Yeah. Like, every chick that I've known—and they never said, "Put on a condom." They're always saying, "Let's do it." (Kent: 656)

> I think [girls] should. Guys should too, but I think girls should think of it more. They should be more open to carrying a condom. I don't know why they don't. I mean, carrying around a condom is kind of like saying "I'm going to have sex," and then you're going to open yourself up to that and you're going to be having sex more. At least, though, if you think you're going to have sex, then have a condom with you. It's better to be safer. (Kurt: 570)

Both Kelty's and Karen's mothers supplied their daughters with condoms. The girls said that their mothers felt that they could at least try to protect their children if they could not do anything to prevent them from having sex. Both girls were grateful that their moms were open to discussion on the topic of relationships and sex.

The Influence of Friends

The participants stated that friends greatly encourage each other to use protection to keep themselves safe: "I tell my good friends to use condoms, and so I look out for my friends now, so it's like what comes around goes around kind of thing" (Kent: 769). Some interviewees identified problems with going to friends for information. Friends had a tendency to try to say the right thing while doing something completely different. Saying "yes" to condom use is the fashionable answer, but embarrassment and ridicule will sometimes prevent friends from sharing their true feelings towards contraceptive use.

> But when I talk to them [friends] they'll tell me their story and something like that, and I always ask, you know, "Did you – you were smart and you used protection?" Sometimes no, sometimes yes. Or sometimes they'll say yes, and I'll find out later that they were lying, because they'll talk about it with someone else. (Kurt: 374)

Condoms vs. the Other Methods

Along with comments on condom use and safe sex experiences, some respondents talked about other methods of contraception. The withdrawal method was popular among couples who had been dating a while and wanted to get more "feeling" out of intercourse. Other reasons supporting this method included "sometimes we just don't have condoms available" or "my girlfriend has an allergy to pills and latex." Kyle described how the withdrawal method might not be the most reliable form of birth control:

> I don't think that the withdrawal method is very reliable, and we rely on it the most. I can remember a few times I haven't, I didn't take it out. The first time she just—whoosh! She didn't hit me because she doesn't believe in pain and causing another pain, but she was like, "Fuck you!" (Kyle: 668)

Two of the youth interviewed talked about Depo-Provera injections or Norplant as better, more effective forms of birth control for teens. "At least they provide protection for months at a time, and you do not have to worry about taking a pill at the same time every day: I was on the pill but took myself off because if you can't be on time and you can't whatever, you just make it all that much easier to get yourself pregnant, and I'm not a time person" (Katy: 1026).

The comments indicated that it was a common occurrence for girls who were on the pill not to use condoms. The girls said they assumed if you were with a steady boyfriend, then they already knew that the two of them were clean, and one only had to worry about getting pregnant. Other adolescents said that one must be as careful as possible these days and should always be thinking of avoiding both STDs and pregnancy. Four respondents, two males and two females, said that they try to use both condoms and the pill simultaneously to cover all the bases:

> I think she's on birth control; I think she's on birth control. But you can never trust those things either. (Kent: 636)
>
> Yeah, [girls] should take birth control pills; they should be used, even if you're using condoms. Why not? It's better to be safe than sorry. I know it's not the most convenient thing in the world, but neither is a condom. (Kurt: 580)

Katy summed up the underlying factors in adolescent decisions to engage in sexual intercourse and to have safer sex:

> And then there's abstinence and condoms and stuff, but condoms and birth control, well, birth control. I don't believe in that very strongly because it really, really depends on a person to be mature enough, to be really decided on the fact that they're serious about what's going to happen to them. But a lot of times too, "Oh I'm on birth control; I don't need a condom." Well, then you've got the fact that, okay, well, you're not just trying to protect yourself from having a kid; you really need to be protecting yourself from getting AIDS and shit too. And I mean, I know I'm only seventeen, and I know a person with herpes, I know a person with AIDS, I know two or three people with AIDS, I know people with hepatitis C, I know people—you know. And I probably know a billion other people with a billion other things. (Katy: 1060)

Perceptions of Risk

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The information presented in this section addresses the subject of risk and perceptions of those risks as identified by the adolescents. Although questions pertaining to 'biggest risk' and 'other risks' were asked directly, the teens also responded to related questions throughout the interview process. In addition to the general risk factors, other concepts, such as teen invincibility and self-risk, were introduced to the teens to investigate their perception of the dangers inherent in sexual behavior.

Teen Invincibility

This probe was added to the interview protocol midway through the data-collection phase, as the researcher began to sense that these teens did think they were invincible. Most of the adolescents agreed that members of their generation do believe that they are invincible, or in their opinion, they must believe in invincibility to engage in the behaviors that they have been known to try. A good number of those who discussed this issue believed that youth today are just "stupid":

> Oh, it's totally one hundred percent true. Youth today think that they can pretty much do whatever they want and not have to deal with any consequences. . . . They choose not to care about the consequences of things until they have to deal with it. And I think that has a lot to do with their parents and the way they were brought up. I mean, they have enough worries already; they don't need to worry about not having sex. But it's very true of youth today. They think that they can do a lot without getting—having a consequence. (Kurt: 476)

> It's so true. [Teens] think they're invincible because . . . anybody who has got a certain amount of shit really seems to think that they're invincible, or anybody who doesn't have anything thinks they're invincible, because they have this need to believe this; they have this need to believe that they're powerful, that they are something that they—whatever. (Katy: 1094)

> Nobody is invincible, at least in my experience. They feel it it's not going to happen to them because it hasn't, you know; whether they're being safe about it or not, it hasn't happened. It also hasn't happened to anybody in their clique, anybody in their circle of friends, to tell them about it. (Kelty: 575)

Kelty also described her experience with her best friend as an example of someone who thought that she was invincible. Becky (a pseudonym) has been pregnant and has had numerous experiences with sexually transmitted diseases, and yet she continued to have unsafe sexual encounters against the advice of friends, family and doctors: "She's just dumb. And just, nothing sinks into her. She, she thinks she's always right. I'm assuming she thinks she's invincible; you know, nothing's going to happen to her" (Kelty: 592).

Karl suggested that this way of thinking can be a carryover from attitudes towards other events in teen' lives. He implied that when one is with a group of friends one feels that any problem can be tackled because buddies will back one up:

> No, I wouldn't say they think they're invincible about that, but yeah, it applies to most things other than that. But when it comes to that [sexual risks], it's a disease; it's not something you can beat up with a bunch of people. (Karl: 450)

Kent (569) summed up this topic very well when he said, "If people think they are invincible, then they are stupid, right? Because no one's invincible, everybody's a human being, everybody's the same, everybody's made of water, everybody's, like everybody's skin and bones."

When asked the question, "What do you see as the biggest risk associated with sexual behavior?" the youth responded with three main areas of concern: pregnancy, disease, and emotional damage.

Pregnancy as a Risk

Seven participants (four males and three females) chose pregnancy as their primary concern during sexual intercourse. One female chose pregnancy as a secondary concern. Two female respondents were currently parenting their children. Kelty, 19 years old, had been parenting for three years at the time of the interview. She had left school when she became pregnant and was trying to finish her high school diploma through correspondence. Kelly, 17 years old, gave birth six months before the interview; and although she lived independently, she planned to return to school the following semester. Katy, 17 years old, was entering her ninth month of pregnancy and reported mixed feelings about her future as a teen mother. Karen, 18 years old, was debating whether to keep her baby or give it up for adoption. Lastly, Kevin, 17 years old, who had had an extensive list of sexual partners, had just been told that his girlfriend was pregnant:

> If I'm in a position where there's sex, then it's already been discussed and I know that the person I'm with is clear of all diseases. So the only real risk—I mean, in my situation, the most risky thing is pregnancy. (Kurt: 223)

> Well, I think with kids my age, I think it's more, more common for, for a girl to get pregnant than to catch a disease. (Kelty: 256)

Of the participants who did mention pregnancy as a possible risk factor, two categories of responses emerged from the data.

Becoming pregnant. In this sample of ten, no one wanted to get pregnant. Most were "scared" that they might get pregnant or become pregnant again. Of the teens who were or had been pregnant, some felt "stupid" for getting into the situation in the first place. Finally, the decision of whether to abort the fetus, parent the child, or put the baby up for adoption weighed heavily on the young females.

> I didn't want to get pregnant. I was very scared of that. (Kelty: 190)

> I have to do what I, what I did to myself. I have to do that. I have to deal with it. And so that's the way I looked at it. Well, you were stupid; you'd better deal with it, you know? (Katy: 915)

What if . . . ?

> Yeeeeaaaah! That's why I use a condom. There is no way! There is no way I'm going to get a baby, no! Because if I have a baby, it'd be like you're stuck; it's there. You're the daddy. He'd depending on your ass now. (Kent: 588)

> We were just fooling around and he was like right there. And my period was a week late, and that was when I made sure that I was on the pill regular and every day, the same time, because that was like the worst scare ever. (Karen: 450)

There was a range of comments on the possibility of having children. Some of the youths said they had talked about pregnancy in their relationships and thought that, although they were not trying to have children, it would be "cool" if it happened:

> We had talked about what happens if she gets pregnant. I mean, you don't really know until it happens, but we had talked about it, and we were comfortable with knowing that everything would be cool if something happened that we didn't expect. (Kurt: 242)

Some of the males brought up the tendency for males to disappear after their girlfriends tell them that they are pregnant: "You know, a lot of times [you] can take the easy way out—run away." They revealed how difficult hard the decision would be if something such as a pregnancy happened to them. Many of the adolescents alluded to a pregnancy as being more serious than an STD. Pregnancy is more urgent, harder to "fix," and more of a moral dilemma:

> Most people would think, would be a lot more scared if one day they woke up and they were pregnant than if they woke up and had some STD. Just the perception that if you have a kid, there's so much more moral issues behind it: Are you going to abort it or not? And all that. (Karl: 343)

The adolescents interviewed mentioned how difficult it becomes to reach their goals if they are focused on supporting a child and a relationship at the same time. Most admitted that this was not an easy accomplishment at such a young age:

> Pregnancy, and there's a risk if you're not stable, if you're a kid, if you're a teenager. You haven't experienced life. You're not even grown up yet, and you got this baby of your own. . . . If a child is born into a destructive home, it can become an instrument of destruction. You intake what you experience, and then

> you release what you've interpreted. So if all you've experienced is deprivation, pain, and heartache, then that's what you're going to emit. So if the wonder of life is born into death, destruction, demise, then that's such a tragedy; it's just a terrible thing. It happens so often. (Kyle: 628)

Handling Pregnancy. Pregnancy options were also discussed by the teens in this study. In addition to parenting the child, the most common choice in this sample, teens also thought about adoption and abortion. With regards to adoption, the males interviewed did not have much to say on the matter, but the females agreed that they would find it difficult to carry a baby to term and then have to give it away to a family they knew nothing about:

> The thought of giving up my baby was hard. You can feel it; it's your baby; it responds to you. It's a part of you. . . . Then if you are adopting, you can't—you know that it's not going to have the morals that you want it to have. It's not going to know the things you want it to know; it's not going to know 'you' necessarily; or even if it does, it's, you know, you're not Mom. (Katy: 965)

> And adoption would just not work for me. I could not carry something in my stomach for nine months and pass it away; I couldn't do that, especially as I went throughout my pregnancy, and you realize you get such a bond with the unborn child. (Kelty: 382)

The dialogue on abortion was much more involved, with some strong viewpoints voiced on either side of the debate. Of the ten who responded, one females and three males were in favor of the procedure, whereas three females and two males were against terminating a pregnancy. One male was undecided.

Those in favor of abortion reasoned that teens do not have the economic stability necessary to raise a child and that they would not have the opportunity to finish school if they became parents: "If I was to have a kid [now] I'd want an abortion until I was completely economically stable. Like even if I was in university, I definitely would" (Karl: 474). Those from broken families said that premature parenting would perpetuate an already unstable living situation that would not be suitable for either the child or the youths: "But that is, on a scale for abortion that's the reason it can be acceptable. There's no reason for perpetuating destruction" (Kyle: 918). Some also mentioned that those in their age bracket simply do not realize the responsibility of raising a child. Although no one was completely in favor of the procedure, they saw how the option might be the most realistic choice in certain situations. In addition to weighing out the options, those in favour felt very strongly that abortion should definitely not be used as a form of birth control: "But then to get pregnant every other month and go have an abortion, I think that's ridiculous, and you might as well get fixed" (Katy: 893). Katy, who was nine months pregnant at the time of the interview, revealed: "If I could go back now and have an abortion without anybody knowing, I would" (924).

Four out of five responders who felt that abortion was not acceptable labeled the procedure as "murder." The overriding view was that if one gets pregnant one is responsible to see one's mistake to its natural conclusion. One is responsible to either parent the child or give it to someone who is willing to adopt the baby. "Murdering" and "killing" are not acceptable means of correcting mistakes.

Disease as a Risk

Of the eight participants who answered this question, four (three males, one female) chose disease as their primary risk factor and four (two males, two females) as a secondary risk factor after pregnancy (see Table 2).

Table 2

Breakdown of Disease as a Risk Factor in Sexual Behavior

	Nonspecific response	HIV/AIDS	STDs
Primary response	1	3	1
Secondary response	0	3	4

The number one reason that disease was identified as a secondary risk factor was that there was a general knowledge that some of the infectious diseases (herpes, hepatitis) can remain for a lifetime and that some (AIDS) can be fatal. Keith had a personal experience with AIDS because two of his friends were HIV positive, and he realized the permanency and finality of this diagnosis. Kevin highlighted the threat of acquiring an STD when he said: "STDs are so common now; like, it's just going so, like a grass fire; it's just spreading" (Kevin: 200).

Comments related to disease as a risk were categorized into: gut responses and personal experience. Gut responses, or those which elicited an emotional reaction, included views such as that STDs are "gross," "they suck," and "they can be stealthy":

> I think it's gross, but I guess it is preventable, but some people get it, and you can't do nothing about it, I guess. (Kelly: 271)
>
> The genitals these days are like a sewer. You don't know what's in them; it could be anything, like so much shit, so much rat infested. Or, it could be like a pure stream of flowing water. I figure once you lose your virginity it's like having a factory dumped on your pure mountain lake. (Kyle: 705)

Personal experiences were woven into other comments made and included those statements about friends who had contracted some kind of STD—"She has herpes. She has been able to keep it under control. She's had genital warts; she's had chlamydia"—and those who had not been personally affected by STDs —"Personally, I don't know.

Like, none of my friends have really ever had it." Everyone stated that one has to be careful about with whom one is sleeps because the diseases may not be visible, and the partner might not know he or she has been infected until it is too late. There was a clear message that some nasty things that can have a lasting effect on your reproductive system ca be contracted. Most, however, had not had first-hand experience with a disease and thus had not formed an attachment to the STD threat.

With regards to HIV/AIDS, there were two ideas. First, most teens have seen pictures of AIDS victims and the suffering they endure throughout the illness. The permanency of this disease made an impact on the study population. They knew that if they got AIDS, they would die: "I'd rather die from a bullet standing up than a guy in a hospital bed saying, 'Hey, see you later, man. You know, I got AIDS,' you know" (Kent: 414). Second, although the teens interviewed saw HIV as a global threat, they had some problems seeing it as a personal threat because many of them had not had personal experience with the disease. Their distance had created a comfort zone for their behavior. Only one respondent felt that he might have put himself at risk; he subsequently went to the clinic for an HIV test.

The Emotional Risk

An emotional risk became a theme in this study. It was one of the most profound risk factors for this age group. Kurt was the first to focus on this factor, and his words spoke for themselves:

> I don't know if it really has anything to do with the study, but there's a risk of the relationship going in a different direction. When you have a relationship and there's no sex, and then you have sex, it's a different, it's a total different way; the relationship is a different, different thing. . . . There's more emotion involved, for me anyway. I find that I care about the person a lot more if we're having sex. (Kurt: 255)

> There's always an emotional risk, you know. There's an emotional [aspect]. Like, I always felt unable to do what I thought I should be able to do. When it came down to sex I felt confused, and I didn't know any more what I was looking for. (Katy: 711)

As Katy and Kurt mentioned, there is more at stake in a relationship than the physical consequences of intercourse. Kurt focused on the nature of the relationship and the process of committing to one person, and to an intimate act. He felt that one has to be careful when one invests time and 'emotional energy' into a relationship because couples run the risk of being hurt by their partners. Katy was leery of the motives behind her sexual relationships. In her experience, emotions can become confused, and sex is sometimes introduced to the relationship for the wrong reasons. Kelly added her views on the subject when she said that she worried about "sleeping with the wrong guy." Again this goes back to Kurt's position that, inevitably, it may be your partner who hurts you more than any physical condition.

Kyle took a different, more humorous view on the emotional risks facing young couples these days: "I don't know, another risk, I think, for a lot of teenagers, what they worry about most is getting caught, their parents finding out" (Kyle: 682).

Self-Risk

When asking the question, "What do you perceive as your biggest risk associated with sexual behavior?" the researcher sought to gain more insight into the personal or self-risk of these same behaviors. Obviously, there are two main responses to the question "Do you feel personally at risk when engaging in sexual behaviors?" Six participants did not feel at risk of a negative outcome of sexual behavior. These three females and three males reported knowing how to protect themselves, and although they did not specify their methods, they also said they took precautions:

> I think about it; I think about the risks and stuff. And I know that I don't want to get a disease, and I know that I don't want to have—get somebody pregnant, and I know all that stuff, so I also know what I have to do to avoid it. (Kurt: 470)

Those who did not feel at risk stressed the importance of "researching their partners" in order to find out about prior experiences and potential diseases. A common perception that was expressed that it was okay to use birth control methods such as withdrawal and the pill alone if one is with a steady partner. Another interesting finding was that, of the teens who did not feel at risk, two of the females had given birth and one male had just recently been told that his girlfriend was pregnant. Accidents are one thing; but teens viewed risk as another. Some of those who have had unexpected experiences in the past were more likely to feel at risk than those who have not had any reason to take precautions: "Granted, I love children and I love my daughter, and I wouldn't give her up for the world, but I just, I couldn't handle another one right now" (Kelty: 543).

Two males and one female felt that they were definitely at risk when it comes to sexual behaviors: "Somebody started to scare me the other day and tell me that this chick I had fun with had AIDS, and I'm like, "Yeah, okay, whatever." It makes you think about [risk] after that little scare. (Keith: 254)

These teens knew that if one decides to engage in sexual acts, accidents can happen, and therefore one is at risk and must take the necessary precautions. The solutions offered to decrease the risks included "toning down" sexual activity, "limit[ing] the number of partners you have sex with," and researching your potential partners' sexual history: "You have to make sure and check it out." Another suggestion given was to use multiple forms of contraception (pills and condoms) to protect oneself against disease and pregnancy.

> I'm sure there's a threat, definitely a threat out there. I mean, how much of one is another story, because it all depends on the person. If you're having sex with a different person every week, you're going to have a chance of being affected a lot more than, say, someone like myself, because I've only had two partners. (Kurt: 536)

Sexual Health Education

The participants were asked their opinions of current education that focused on safer sex or sex education. Four main convictions were voiced when addressing this question. Positive responses suggested that education outlined at present was *important* to today's youth. Seven teens, one female and six males, made positive comments about current sex-education initiatives. The totality of educational efforts were described as *educational, enlightening, useful, helpful,* and generally *a good thing.*

Negative responses were encompassed by the umbrella term *insulting*. More precisely, education that was marketed to inform youth of the pitfalls of early, unprotected sexual activity were *repetitive*, *corny*, and *cheesy*. In general, education was viewed as *ineffective* because, as three of the teens put it, "No one pays attention." The number one reason that "no one pays attention" was the phenomenon known as *teen invincibility.* The teens said that they do not care because they "don't believe it will happen" to them. This "it" could be anything from pregnancy to disease to death.

School

Three males and two females felt that school adequately prepared them with basic sexual health knowledge. The main topics covered included contraceptive methods, HIV and STD transmission. Karen, said her sex education class broke up into small discussion groups to facilitate questions and discussions. Techniques of this type were found to be very beneficial to other students:

> We did lots of discussion groups on the topic. There was one where you could ask lots of questions. . . . It was taught really well. That was the most helpful stuff because at that time I didn't know anything about that stuff and it was good to learn. (Karen: 441)

> And the only way I can judge that they are effective is because we learn about all this in school, and we got these dangers pounded into us. How else could we know? . . . You've got to learn somehow. Why not learn in school, I guess? (Kyle: 869)

> Then you start watching all these videos and they start doing demonstrations on how to put condoms on and all this stuff that you've never seen before, and it's kind of shocking. But seeing that stuff was definitely—it was educational. (Kurt: 450)

Some of the teens suggested that sex education start at a younger age. They thought that basic concepts might be introduced earlier and information continually, gradually integrated throughout one's school career. In addition, some youths thought that the current content level of information was not explicit enough to be well understood. For example:

> I think that it should be, instead of just going into a school one day and hitting these kids with a lot of stuff, they should slowly integrate them into it somehow. I don't know; I'm not a professional in this. I think if they just give them little pieces of information at a time. (Kurt: 444)

Three other respondents, two females and one male, believed that their school education was insufficient. Four reasons surfaced to explain these very different experiences.

> The teachers were not adequately prepared.

> Well school didn't help at all. They were—teachers are just, they're too shy to discuss the kind of things that need to be talked about with young girls, especially when some of them in the class are sexually active. (Kelty: 678)

Kelty also felt that the most important information concerning teens and sex was absent from the curriculum. This includes how to communicate effectively with one's partner, proper instructions on how to use contraceptives, and troubleshooting techniques:

> But they don't say, "Well, this is how you're supposed to use it" or how effective it is or, or what you could use with it to be a hundred percent sure, blah, blah, blah, and stuff like that. I think that would have prevented quite a few pregnancies that girls went through in junior high. Also comfortable ways to bring it up to your mate about discussing safe sex, which I think is very important. If you can't, if you can't talk to your partner about having safe sex, you're obviously not ready to have sex with him. Well, just little things that they, they should have

> broughten up, but didn't. It didn't help either that I was taught sex by an old fart who's like fifty. (Kelty: 689)

Some schools did not have sex education programs.

> I never really had any program in that school like that. [And how much do you know or have you learned about HIV and AIDS in school?] Not very much. (Kelly: 343)

Some of the education programs did not have an impact on the students: "I didn't really—I just kind of breezed through it. I don't even remember sex education. Not too many [teachers] have talked to me about it" (Kevin: 367).

At times the sex education classes were not timely:

> A lot of it people don't listen in school when [sex education] is being taught. STDs and stuff I was interested in because it could become a possibility and stuff, but if you aren't in a relationship, then you don't pay attention because it doesn't concern you at that point. When it came to health class and stuff it was just a joke, it always is. (Karen: 430)

Parents

Four youths, three females and one male, reported confiding in parents and asking them for information. Keith, Kevin, and Kurt had not had contact with their parents in the last three years. Some parents were very open with their children, with the parent of choice often the mother. Some of the teens reported that their parents encouraged discussion on everything from sex and health information to individual sexual acts. A few parents allowed their teens to have sleepovers with their opposite-sex boyfriends/girlfriends. A couple of the teens, both females, received condoms and were taken to the clinic to obtain birth control by their mothers. The teens in support of the parents as an information source preferred hearing advice of this nature from their parents, but they especially wanted accurate, unbiased details free of condescension:

> My mom and I talked about that kind of stuff often. I got a lot of my sexual information from my mother. Both my parents, my mom preferred—my dad would shit if he heard her talk about this—but my mother preferred that if any of

> us kids, be it my brother of my sister or myself, if any of us are going to have any kind of sexual activity, she would prefer it to be in her own home. (Kelty: 214)

> I remember I asked her once about how you give a guy a blowjob, and she gave details about it and was really good about it. She is good about it, and she is lots of fun to talk with. She is really funny. She tells you what you need to know; she doesn't hold back. She says, "Whatever you need to know, just ask," because she would rather have you ask then you going behind her back and trying something. (Karen: 461)

> Most people learn about sex from their parents eventually. They have their talk about the birds and the bees. It's just something a parent's got to do. . . . Parents are a valuable resource. I think it's the most important; it establishes a bond between the parents and the children instead of receiving it all from the teachers or from the curriculum. (Kyle: 970)

These adolescents were in agreement that parents should be open and honest with their children. The teens said that sheltering them was not good because they would satisfy their curiosity from different, often uninformed sources. Those who felt that their parents had not been of much help in their sex education complained of the following:

- Parents did not supply useful information.
- Parents discouraged any kind of sexual health education.
- Parents did not establish a trusting relationship with their child.

> My parents just told me not to have sex, period, because it's too much responsibility. (Kurt: 318)

> [My parents] think I should be home by eleven o'clock, and I shouldn't do anything, which I do. (Karl: 558)

> My parents won't let me, because they think that if I learn more, I will want to do it. (Karen: 202)

> Oh, sex information. Well, there's no way I'm going to Dad. You know, Dad's going to be like, "Oh, yeah, just, just do it!"(Kent: 779)

Kelty and Karen had plans for their children when they grew up. Both intended to make it clear to their children that if they wanted to learn about anything concerning sex, they should come to them:

> If she has any questions, she can feel comfortable to come and discuss it with me. I'm going to be perfectly open and honest with her about everything because my mother was with me. (Kelty: 705)
>
> Well, if my kids wanted to learn, I would let them learn. But if they don't want to learn, it's their choice. (Karen: 370)

Additional Education Sources

This category can also be broken down into four response options: friends, radio, Internet, and advertising campaigns.

Friends. "I think it usually comes down to friends when it comes to teens, that most of the time it always comes down to friends" (Katy: 1199). Friends were said to influence through support and pressure. As Kelty said, "Your world consists of your circle of friends." It is common that if your parents "don't understand you," you can go to your friends. Teenagers said that they feel more level with other teens of their own age. "That's why curiosity is a big teacher; [teens] go to each other. (Kyle: 966)

Most of the time teens will discuss personal stories and questions with a couple of close friends or on a one-to-one basis. The teens trust these friends and go to them for information. A caveat, however, is that friends of one's own age may not have completely accurate data to share. Therefore, teenagers reported that they have to be smart and discerning about the advice they receive from their friends:

> It is nice to get information from your friends, but they have to know the right information to give to you. People do know things in our age group; [teens] are not completely careless about sex. They do take precautions. (Karen: 548)
>
> They are the only one that knows what they know, and you can't really take the word of someone else; you just have to be smart about it. I wouldn't say too much about friends, because most of the time when you're with your friends, a lot of the stuff is altered just to make things sound like they're, you know, not—I mean, people do tell fibs about stuff. (Kurt: 295)

Media: The Sue Johansson Show. A few of the participants identified this show as one of their chief information sources. They felt that Sue Johansson speaks with a "no holds barred" attitude, and that one can learn a great deal from just one show: "My boyfriend knows a lot about that [sex] stuff because he listens to Sue Johansson on Sundays"(Karen: 444). The teens said that they trusted her because she is honest and frank about even the most sensitive sex subjects:

> I like [the *Sex Show*] because she talks about the most disgusting things and that's good, because, hell, I don't know any of these things. I've never heard of this, I never knew about genital warts and stuff and all these things, and it's like, oh, that's disgusting . . . I think things like that should be in school. . . . I think the lady is awesome! I really think that she opened up a lot of people's eyes, because I'm telling you it opened up my eyes a lot more, and it was like something I really wanted to hear. (Katy: 1217)

The Internet. Two respondents said that if they needed more information they could "look up the subject on the Internet."

Advertising campaigns. Some of the print material available on sexual health was seen as useful to the teens interviewed. Kurt spoke of the advertisements and posters in bus and LRT stations: "The bus is where I see a lot of stuff." Keeping these messages in view seems to have an impact on the youth population. Kyle had some interesting insights into appropriate information sources:

> Like different sources for different—if I want to know about orgasms, I'm not going to talk to a teacher. I'll talk to somebody like that I'm close to: my girlfriend, my friends. If I want to know a little bit about something like statistics, or about raising a kid, or the stages of development, then I'd go to a teacher or something. (Kyle: 952)

Designing an Educational Message

The participants were asked how they would design a sexual-health educational campaign to educate their peers on sexual behaviors. The responses to this request took many forms:

Actual slogans. Four teens, two males and two females, suggested slogans that they might use to get their messages across: "What's love got to do with it?" "Condoms—Use it, don't abuse it," "STDs Suck," and "Don't Do It" (the Nike generation).

Tone/delivery. Some of the teens interviewed focused on the tone or delivery of the message as the most important step in campaign design. Two routes were discussed by the teens. The number one tactic was to use humor as a way to get a message across. Humor is eye-catching, memorable, and repeatable, and appeals to everyone. Cartoons were suggested as the favorite format for this design.

> So if you make it like funny, people are going to be like, "Oh, remember this? Can you remember this commercial?" You make the commercial funny, and people will listen, because they like funny things. They don't like, "Hi. My name's John Smith, and blah, blah, blah. We are here to tell you about sex." People just like a joke. (Kent: 529)

The second most popular tactic mentioned was to incorporate shock into a message. Shock conferred a certain amount of reality to the campaign. It was seen as an attention grabber that could make a lasting impression. Scare tactics were favored by some teens as the best ways to make a bold statement. Things such as SEX, nudity, and especially "real-life" pictures and stories about people who have had bad experiences were seen as the key to an effective campaign:

> Shock. Showing how quickly it would come to you if it did happen; what you would see and how surprised you would be. (Karl: 366)
>
> Show them somebody with AIDS that's dying. "Look what can happen to you man so put a rubber on." I think the best way is to scare them. (Kevin: 249)
>
> With shock. You'd want to get the attention, first of all, so you don't really need to do much. You just need to put S-E-X on there and people pretty much notice it. But I mean you want to get the attention, you want to have some shock; you want to tell the truth. I mean, you want to tell people what's really going on. (Kurt: 400)

Content. Content was identified as the most important piece of the puzzle. First one has to get one's target group's attention, and then one can feed in the desired data:

> If you want to educate people about the bad things, you've got to appeal to them at first to get them to pay attention, because if they just hear negative stuff and bad things, they're not really going to want to hear it. (Kurt: 419)

Most teens agreed that preaching turns them off. Anything that sounds "parental" reeks of condescension and an "I told you so" mentality. Realism is also a strong feature of effective campaigns:

> Emphasize more on the risk of getting a kid than the risk of getting AIDS at a younger age, because it's not there so much. (Karl: 338)

> Hell, they should have—and, and I wish they'd come out with some movies with some beautiful girls that go out and fall in love or this fairy tale with some nice-looking man, but the next thing you know, they've got AIDS. Because everything you see, it's always perfect. These perfect girls find these perfect men, and nothing ever happens to them. (Katy: 1248)

Karen also mentioned that campaigns do not need to be too graphic or sexual to make a point. Sometimes this kind of message will just "turn people off." Another factor that was seen as important was to design age-specific messages, because the content must be viewed as age appropriate to be effective.

Medium. Almost all the participants agreed that education on this subject is best received through the audio/visual route. Anything that shows "live action" and the words of real people has more impact than merely looking at posters.

Factors Influencing Teen Sexual Behavior

At the conclusion of every interview the adolescents were asked to describe their version of teen sexual activity in the 1990s. In other words, they said what they thought made teen sex so attractive. Some common threads ran through the responses. The main themes include motivation, age, education, and perception. *Motivation* refers to the rationale behind engaging in sexual acts at a young age. *Age* denotes a physical property or a mental/developmental state. *Education* refers to the sources to which the youth look for information and guidance. The fourth theme is one of *perception,* in which guiding principles are revealed that may be followed by all youth or only the individual speaking.

Keith suggested that "[teens] think it's cool or something" when referring to early initiation of sexual behaviors. This addresses the idea of motivation as an underlying factor for sexual initiation. The motivation here is to be "cool," but it is not clear who is the judge of "coolness." Karen began by saying, "They listen, but listening is one thing, doing is another." Her perception was that having the knowledge is one thing, but that does not necessarily mean that a behavior change will occur. How knowledge can lead to behavior change was not discussed.

Kelly believed that, to teens, sex is like "a new invention." The motivation in this case is curiosity, in which as children learn about new activities, they naturally want to test the waters. Her perception of the teen sexual revolution was that teens are going to "do it anyway," so they should be taught to do it properly.

Karl also discussed curiosity as the primary motivator for youth to experiment with sex. Karl addressed the education theme when he mentioned the combined influences of school, family, friends, and especially the media. The media marketing of condoms has been very prominent and, in Karl's mind, had no doubt had an effect of planting the seeds for early sexual activity. Age was also discussed by this youth when he spoke of siblings and life experience as having an effect on the mental age of some adolescents. It was his view that his older brothers exerted great influence on his activities and knowledge in certain areas. He also felt that this could be true for those teens who were independent at an early age. Having had more like experiences, whether actual or vicarious, contributed to an older "mental" if not physical age.

Kevin agreed with Karen when he remarked that youth "know it but don't use it," following again the perception that youth today have been equipped with the knowledge to make decisions regarding sexual behavior, but have not necessarily received the skills for behavior change. Kevin explained *motivation* as a desire to do something "forbidden." He used current movie releases to illustrate the point that the mere viewing of material of a sexual constitution are restricted until one reaches 18 years of age. To forbid sex fuels teen's "curiosity" as to what is so special that only adults are allowed to partake in these activities. Kevin's perception was that teens are so anxious to sample adulthood, they "pretty much go for anybody available," which amplifies the statistics on teen sexuality.

Kent again emphasized the curiosity aspect of teen motivation. "Everybody wants to be a little bit older when they are younger." Kent's perception is that the exposure to sexual influences is greater today than it was in the past. Information penetrates at a younger age, whether it is through older siblings or even cartoons and movies which fail to receive the restricted ratings. He stated that teen sex is a "sign of the times" and that people are not "so goody-two-shoes" in this day and age. Today's teens "don't give two shits" about what others deem appropriate behavior for their age group. Kurt focused on peer group pressure as a key motivational aspect for teen sex. His perception is that the composition of a peer group can have a variable effect on whether teens will engage in sexual behaviors at a young age:

> I think it has to do with the way people are at a young age. I mean, if you go into junior high and you're popular and you have a lot of friends and there's girls that like you and you have girlfriends and stuff like that, maybe you're going to have sex at a younger age. But if you go and you're a nerd and you don't have any friends and girls aren't attracted to you, as a guy anyway I can say that, you're not going to be affected that much. You know that there's really not that option. (Kurt: 619)

Katy elaborated on the motivational theme of teen sexuality: "Curiosity is confronting the unknown." As one grows from childhood to adulthood, there are many lessons to be learned, and teens will continue to try to satisfy their curiosities. Katy also introduced the concept of peer pressure as a possible motivator for teens. Adolescents "want to be accepted," she said; and in order for this to occur, they sometimes must engage in acts and behaviors before they might otherwise be ready. Katy also discussed age in a developmental sense. She said that at a certain age youth will listen to adults for information and advice, but after this they think for themselves, and one will have a great deal of difficulty trying to tell teenagers what to do. Katy has a dim perception of teen life today:

> Life right now, life with teens and sex and just growing up and learning about growing and facing reality is a sad story; it's just a sad story, period. And I don't know if it'll ever get better. It's hard to believe, right now especially. (Katy: 1265)

Kelty again described her teen-sex theory with regards to an age component. She said that teens "want to act like adults" and do adult things to show their "maturity." Sexual behaviors are termed *adult activities,* and therefore it is only natural that this area be high on teens' lists of areas to explore. Kelty listed a number of possible motivational factors. Peer pressure was mentioned with regards to friends, partners, and society in general. Kelty referred to positive peer pressure in addition to the commonly felt negative peer pressure. In her experience, there was a difference between peers exerting negative pressure, ridiculing those who do not conform, and passive pressure, resulting from "girl talk" and off-handed suggestiveness. Abstinence can motivate teens to refrain from sexual activity as a result of religious beliefs or a desire to "save sex for marriage." Curiosity, experimentation, and the need to collect experiences were also featured in her inventory of motivational factors.

Kyle had much to say on teen sexuality in the 1990s. His motivators included the aforementioned peer pressure (once again alluding to both negative and passive pressure) and experimentation, but he also broached the topics of self-esteem and competition. Competition was simply "keeping up with the Joneses," a self-inflicted desire to make sure that you were in the same league as your friends. Self-esteem is built when you gain the affection of others, and feel that you are desirable. Kyle talked about age playing a role, as adolescence is the time when "hormones kick in" and teens become more adult and less childlike. It was Kyle's perception that sex these days is not "taboo" as it once was and that teens are in a rush to get to the adult world. This is a world that is based on sexuality, or at least it must be to feature sexual behavior in almost all movies and television shows

> It's a thing with the adult world, the sexual activity they see on TV all the time, the boss with the secretary or whatever, whoever, anywhere. They're always having sex. Everybody's having sex. Our whole society is based on it. So then there's all this influence, and then they start wondering about it for themselves: What is this all about? They have these pictures of explosions and like, oh, wow! This is the great wonder of sex. . . . So it's not only a physical attraction, it's also curiosity. Like, oh, man! Curiosity is so appealing. You want to know; you want to know more. Basically the only way you can know is by experience. (Kyle: 279)

CHAPTER V

DISCUSSION

The adolescents in this research shared their thoughts, feelings, and experiences in order to explain their perceptions of sexual behaviour and sexual risk. From these discussions emerged a model of adolescent sexual behaviour and sexual risk (see Figure 4). A tree was utilized to depict how the themes discovered in this study interplay and affect adolescent sexual activity. The tree symbolizes the growing process from childhood to adolescence to adulthood and the model outlines the necessary components for sexual development. The researcher sought to answer the question "What are adolescent's perceptions of the key elements of sexual behaviour and sexual risk?" It was found that sexual health education, risk perception, and previous sexual experience impact on adolescent development, sexual behaviour and sexual risk taking. What follows is a diagrammatic representation of these findings. In this chapter the relative components of the model will be discussed in light of the existing literature. Next, the strengths and limitations of the study are presented, followed by implications for practice and directions for future research. Finally, comments are offered on the relationship between adolescent sexuality and health promotion.

Environmental Factors

The Sample

Past quantitative and qualitative sexuality studies have mainly focused on middle-class teenagers. All socioeconomic levels deserve a voice in the research and strategies which seek to impact their lives. Socioeconomic status, family life, and school experiences have been determined to have multiple effects on the sexual development of adolescents (Benshoff, 1993; Brooks-Gunn & Furstenberg, 1989; Millar et al., 1993; Peterson & Leffert, 1994; Ramsum, 1993). This sample of 10 teens was composed of

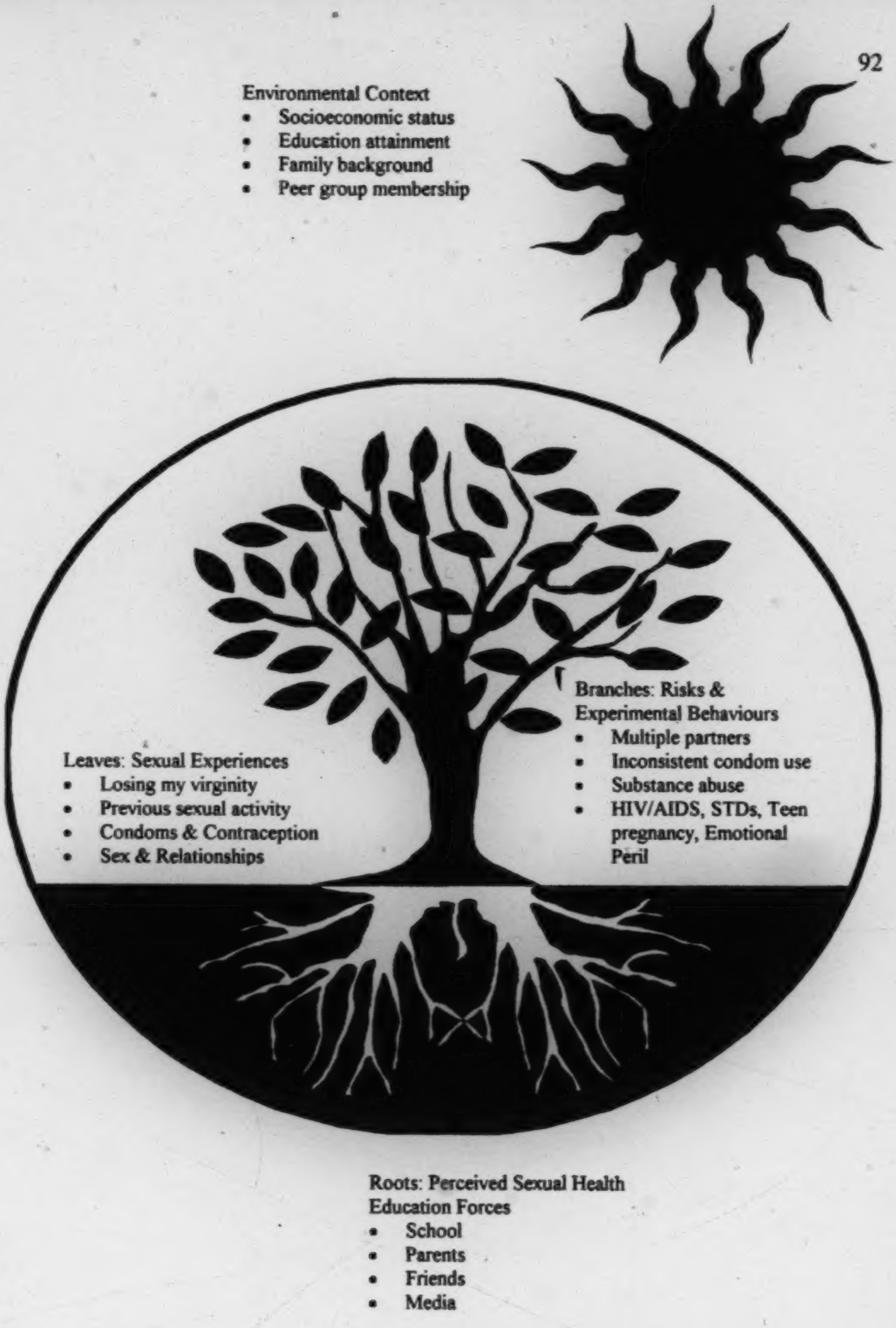
Environmental Context
• Socioeconomic status
• Education attainment
• Family background
• Peer group membership
Leaves: Sexual Experiences
• Losing my virginity
• Previous sexual activity
• Condoms & Contraception
• Sex & Relationships
Branches: Risks & Experimental Behaviours
• Multiple partners
• Inconsistent condom use
• Substance abuse
• HIV/AIDS, STDs, Teen pregnancy, Emotional Peril
Roots: Perceived Sexual Health Education Forces
• School
• Parents
• Friends
• Media

Figure 1. A Model of Adolescent Sexual Behaviour and Sexual Risk

participants who displayed indicators which placed them into the sub-culture of "at-risk" youth. Key monetary and support system advantages were found to exist for the two negative cases, thus for the purposes of this study they fell into a separate sub-culture of adolescents. Their perceptions of adolescent culture as a whole are not included in this study.

A majority of the at-risk youth in this study had been periodically involved with juvenile facilities in the past five years. Poulin et al. (1997) examined the various ways in which youth become a product of such facilities. The Canadian Youth Protection Law was designed to protect children who were physically/sexually abused, runaways, drug users and prostitutes. The Young Offenders Law deals with delinquent youth as well as antisocial behavior. Health and Social Services in Alberta takes care of teens encountering family dysfunction and emotional disturbances. Ten adolescents in this study had had experience with one or more of these services in their young lives.

The anxiety that these adolescents face about day-to-day survival often supersedes concern for disease and pregnancy avoidance. Traditional interventions are inappropriate for these youth who, for various reasons, are alienated from "normal or straight" society (King et al., 1988). As discussed in the previous chapter, most of these teens had experimented or were regular users of cigarettes, marijuana, and alcohol. When asked to estimate the percentage of users in the general population, they overestimated the prevalence of substance use among their peers (King et al. 1988). Some participants had experience with acid and cocaine and had spent time in jail for various drug-related offenses. Only 2 of the 10 at-risk youth who were interviewed came from two-parent family units. Both left home due to unintended pregnancies. In general, the family life experiences of these youth were strained due to divorce, alcohol use, physical and verbal abuses, or lack of adequate resources. Most teens reported having a weight lifted from their shoulders upon leaving home.

All 10 adolescents faced academic difficulties and had been in and out of diverse school settings throughout their lives. Kyle claimed to have attended a different school every year from kindergarten to Grade 9. He faced problems with teachers and classmates and experimented with public schools and private lessons for "difficult" students. In three cases, girls were forced to drop out of school due to pregnancy. All 10 interviewees were clients of Alberta social services and were currently on an assisted living allowance. Katy made a valid point which should be taken into consideration:

> And we could live on the drag or anywhere and still be decent people, you know. People think if you're raised down there or if you're raised in lower-income housing that you got to be grubby and that you got to steal and that you got to be an alcoholic or a drug abuser just because, hey, I got a shitty life. Well, that is bullshit, because if you don't want to make more for yourself, then sure that is all you got; that is all you'll ever have. If that is what you are happy with, then fine. But my mom did different than that, and I'm glad. I just wish that I would have maybe realized that I wasn't so different from everybody. (Katy, 292)

Sexual Health Education

Overall, the youths in this study valued sexuality education and found the material presented relevant to youth today. The 10 teens, however, outlined four descriptors that categorized both their opinions of sexual health education and their primary obstacle for behavior change. Education methods and messages are *important* in addressing the major health concerns (teen pregnancy, STDs, and HIV/AIDS) of adolescents. Often these messages were perceived as *insulting* and were thus *ineffective* in achieving their goals, especially if the central objective was abstinence. The problems inherent in behavior modification resulted from a perception of *invincibility*, which is discussed in detail within the risk section of this chapter. Four main sources of information were discussed by the youth in this sample: school, parents, friends, and media.

Schools

School-based programs are essential avenues for providing sexual health education to young people. All the provinces and territories of Canada have such programs, but their extent and quality can vary considerably both regionally and locally (Barrett, 1994). Schools are a particularly important source of sexuality education. As the Canadian Guidelines for Sexual Health suggest:

> As the single formal educational institution to [have] contact with nearly every young person, schools are a vital resource for providing children, adolescents and young adults with the knowledge and skills they will need to make and act upon decisions that promote sexual health. (Health Canada, 1994, p. 11)

The adolescents in this sample acknowledged the impact that school sexuality education has had on their basic health knowledge. The features most prominent included contraceptive methods, STD descriptions, and HIV/AIDS information. The participants in this sample were in agreement with studies which revealed that greater than 90% of parents and students in Canada and the USA value school sex-education programs (Campbell & Campbell, 1990; Kirby, 1993; Sieccan, 1998). The Canada Youth and AIDS Study (King et al., 1988) found that teens acquired information about STDs and birth control primarily from schools. Doherty-Poirier and Munro (1991) reported that 45% to 55% of Alberta youth surveyed preferred the school as their main source of human sexuality information. This study also found that approximately 63% of students chose school as their number one preferred source of HIV/AIDS and STD information. A report from the Kaiser Family Foundation (1996) showed that 69% of adolescents look to sexual health education classes for information regarding sex and birth control. Mckay and Holowaty (1997) found that 89% of adolescents felt that it was important to receive sexual health education. In their study adolescents cited school as their current and preferred source of sexual health information. Mckay and Holowaty (1997) noted that relatively few studies have considered adolescent's opinions and self-perceived needs with respect to form, content, and sources of sexual health education.

In this study the adolescents identified four areas which could be modified in school sexuality programs. The areas included the timing of the education, delivery methods, content, and teacher characteristics. Regarding the timing of sexuality education, the teens believed that it begins too late and that by the time contraception and STDs are deemed appropriate discussion topics, most teens have already experimented with sexual activity. Keeping in mind that teens begin their exploration of intercourse at approximately 14 years, the youth suggested initiating sexuality education in elementary school using basic concepts and gradually integrating information until Grade 9, where most concepts have been fully addressed. Salient features would then be reinforced during high school. This time frame would also be valuable to the "at-risk" populations who tend to drop out of school after Grade 9 (King et al., 1988).

Delivery methods were the second area identified by the teens that could be modified. They valued discussion time and the opportunity to ask questions. Sharing information and experiences in small groups was perceived to minimize disruptions by immature students.

Content was the third area to which the teens referred for revision. They reported that lessons should become more explicit and incorporate hands-on demonstrations with contraceptives. Practical skills were preferred over continuous information dispersal. Most of the adolescents recognized the need for partner communication skills such as condom negotiation and strategies to delay intercourse.

The fourth concern of sexuality education was the characteristics of the instructor or teacher responsible for the classes. Frequently, the adults were too shy, too conservative, and too judgmental to be teaching such a sensitive topic. Relaying educational messages to adolescents requires imagination and refined interpersonal qualities. Without these features, teens take one glance at what they perceive is an ill-qualified instructor and immediately turn a deaf ear to the presentations.

The results of the Mckay and Holowaty (1997) study on adolescent sexual health programs were consistent with this study. They found that teens today valued concrete factual information and skills in the areas of "prevention of STDs," "how to get testing and treatment for STDs," "methods of birth control and conception, pregnancy and birth." In addition teens were receptive to education about interpersonal, communication, and relationship skills. When class time for sexual health education is limited, student priorities should provide cues for the program content, delivery, instructor, and timing. Overall, "informational programs that start with and emphasize these needs can be expected to involve and influence adolescents to a greater degree then programs based upon an adult perspective" (Campbell & Campbell, 1990, p. 190). Effective education and prevention programs provide the "information, motivation, and behavioral skills to help adolescents delay first intercourse and to use contraceptives/condoms properly and consistently if and when they experience sexual intercourse" (Sieccan, 1998, p. 6).

Parents

The Canada Youth and AIDS study (King et al., 1988) found that adolescents' main and preferred source of information about sexuality is the family. In more recent Canadian studies, Doherty-Poirier and Munro (1991) identified the family as the second source of information about human sexuality for at least 15% to 19% of the Albertan students surveyed. McKay and Holowaty (1997) found that 60.8% of students surveyed thought their parents were doing a good job. Yet 39.2% of this same group were unsure or disagreed with this assessment (Mckay & Holowaty, 1997). From the perspective of social learning theory (Andre, Frevert, & Schuchmann, 1989) youth are likely to acquire an attitude that sex has a "bad" component because parents typically try to repress sexual expression in their children. Therefore, adolescents may be inhibited in turning to parents for sexual information. In accordance with this theory, parents patterned to protect their children from sexuality may find it difficult to initiate discussion and communicate information during their child's adolescence (Andre et al., 1989). These theoretical arguments suggest that parents may not be regarded as a major source of sexual information.

This was true for 8 of the 10 youth interviewed in this study. Four adolescents reported confiding in their parents when they required information on sex and sexual activity. These teens reported having very liberal parents who discussed anything from sexual health information to detailed descriptions of sexual acts. Some mothers went so far as to obtain condoms and birth control pills for their daughters. In two cases, females from this sample were allowed "sleepovers" with their boyfriends under the parental assumption that teens were going to have sex anyway, so it might as well occur in the safety of their own bedrooms. The other eight teens found it difficult to approach their parents for information. Three males were not on speaking terms with their immediate families, and one female was not allowed to discuss sexual activity in the house, and her parents forbade her to attend sexuality education classes at school in favor of total abstinence. There were three problems reported with parental communication. These included (a) dissemination of inaccurate, useless information; (b) discouragement from all sexual activity; and (c) a lack of trust in the parent-child relationship.

The effects of parent-child communication on adolescent practices have not been fully examined (Shoop & Davidson, 1994). Shoop and Davidson hypothesized that communication with one's sexual partner and the consistent use of condoms was positively associated with having discussed sexual matters with parents. The findings, however, were inconclusive. In another study, Benshoff and Alexander (1993) found that when parents communicate with their children about sexuality, the children are less likely to become prematurely sexually active. DiBlasio and Benda (1994) reported that inadequate parental supervision, a lack of family satisfaction, decreased quality time with parents, and minimal parental reactions to sexual activity are expected to be associated with sexually active teenagers. This last finding has relevance for this study because the at-risk youth reported that they have, at this time, tenuous relationships with their parents. Parents exert a great deal of influence on all areas of their child's behavior, and thus efforts to affect adolescent decision making must take into account the family life of these individuals.

Friends

Friends provide an ongoing influence and support for developing adolescents. Many sexuality educators and researchers believe that individuals typically acquire their sex education from their peers (Andre et al., 1989). Yet a limited number of studies reinforce this belief. For example, Doherty-Poirier and Munro (1991) found that friends came after school and the family as sources of human sexuality information. DeBlasio and Benda (1994) suggested that weak bonding to parents allows, but does not foster, sexual activity among adolescents by permitting peer associations that reinforce perceptions that the rewards of sex outweigh the costs. This finding was similar to the findings in this study. The teens believed that "when your parents don't understand you," you can always rely on your friends. Therefore, the parent-child relationship can have an effect on the magnitude of influence of the peer group (Whitbeck & Conger, 1993). Close peers are those with an established relationship of trust and understanding; thus they become a fundamental source of sexual health information. Benshoff and Alexander (1993) reminded us that teens can be notorious sources of misinformation for their peer group. The adolescents interviewed in this study recognized this as a fault of "friendly" advice but still valued the peer relationship as a means of testing out ideas and information.

Media

The power of print advertisements, television, and radio programming was often overlooked as an outlet for the dissemination of sexual health information (Andre et al., 1989). However, more recently, a report from the Kaiser Family Foundation (1996) claimed that teens are bombarded with information from many media sources. The average youth spends more time watching television and listening to music than any activity other than sleeping. Doherty-Poirier and Munro (1991) found that after school, television and radio served as teens' secondary source for HIV/AIDS and STD. McKay and Holowaty (1997) suggested that the preferred source of AIDS information is the TV. Likewise, the Kaiser study showed that three quarters of adolescents think that the portrayals of teen sex on TV and in the movies directly impacts their sexual activity, because they believe the behaviors look "normal."

The participants in this research identified the Sue Johansson show as a media source which positively affected their knowledge and decisions related to sexual activity. Teens appreciated the nonjudgmental attitude and explicit information provided. The Internet, although just beginning to receive attention in the realm of sexual behaviour research, is another unlimited source of a wealth of sexual information. No studies were located on the influence of this latest technological advance. Print advertising campaigns, although widely circulated, were considered to be generally ineffective at this point. Most participants offered constructive criticism; the majority were not satisfied that the messages outlined in the posters had any effect on their behavior change. Kyle just shrugged his shoulders and commented: "They're enlightening, I guess."

Adolescent Risk Perception

When asked, the adolescents in this study reflected upon the term *risk* and how it applied to them. They were readily able to identify risk behaviors and the most problematic consequences, yet they did not seem to establish concrete changes to their behavior. Teen invincibility was an idea often linked to perception of risk. Towards the latter half of the interviewing process, the participants were asked directly to comment on this phenomenon. Perceived risks were identified and explained by the teens, as well as proposed solutions and means of correcting their mistakes. Throughout the course of discussion, three categories of risk emerged including pregnancy, disease, and emotional aspects. Finally, the concept of self-risk was probed, and the results show that although adolescents do think about the consequences of their actions, generally they do not feel personally susceptible to the risk of negative outcomes.

Invincibility

Studies by Quadrel et al. (1993) and Whalen et al. (1994) attest to the fact that most people under most conditions view their own chances of misfortune as lower than those of other people. Although the view that illusions of invulnerability are greater among adolescents than adults is an outdated one, there is much to be learned about the motivation behind adolescent experimentation (Cohn et al., 1995). Furthermore age-specific understanding of adolescent's comparative risk judgments are important not only for the formulation of intervention programs, but also because, at least in adults, risk perception has been linked to risky action (Whalen et al., 1994). It has been shown that youth clearly perceive their own risk as substantially lower that that of their peers. The youth in this study were aware of the term *teen invincibility*, and most agreed that in certain situations they do believe they are immune to negative outcomes. However, some of the participants were quick to point out that views such as these are plainly "stupid." Quadrel et al. (1993) noted that the idea of invincibility is not unique to sexual activity and was found to follow a peak initiation period at 16 to 18 years of age. These researchers reported that activities including smoking, drinking, and illicit drug use were also linked to invincible patterns of thought.

The adolescents interviewed in this research were not ignorant of the negative consequences of their patterns of behavior, but many had not had any personal experience with these outcomes and thus had made no changes to their pattern of behavior. Even those who had previous negative experiences were reluctant to label themselves as "at-risk." The Health Belief Model (Gerrard, Gibbons & Bushman, 1996; Hein et al., 1995) has been applied to help understand the variables supporting notions of invincibility. This model asserts that sexual risks are less likely if the adolescent has (a) knowledge of reproduction and the means of transmission of STDs/HIV, (b) knowledge about prevention strategies, (c) beliefs about susceptibility to pregnancy or infection, and (d) beliefs that the benefits of performing preventive acts outweighs the costs. This model as a predictor of behavior change hinges on one factor: susceptibility. The results of this study have shown that adolescents are well versed in reproductive functioning and basic transmission of sexually transmitted diseases. They said that they have been inundated with prevention strategies and methods of contraception. They are aware that the advantages of condom and/or birth control pill use are greater than the disadvantages of loss of feeling during intercourse and delaying or ruining the "mood." Yet the teens could not readily explain how knowledge transmits to susceptibility and, in turn, to behavior modification. They did, however, highlight underdeveloped skills which hindered both communication of intentions and decision-making abilities. Many investigators, including Cohn et al. (1995), Dryfoos (1990), and Quadrel et al. (1993), regard experimentation with risk behavior as a healthy component of adolescent development. There exists a subset of behaviors, however, for which unrealistic optimism and such experimentation may jeopardize the safety of adolescents. The participants in this study perceived three major risks of sexual behavior. They were pregnancy, acquisition of disease, and emotional peril.

Teen Pregnancy

Seven out of ten participants acknowledged pregnancy as the number one risk of sexual activity. This finding is in keeping with those of the Canada Youth and AIDS Study (King et al., 1988), which found pregnancy to be the number one most worrisome outcome among 57% of Grade 11 students, 59.5% of first-year college/university students, and 49% of school dropouts. Congruent with the Canada Youth and AIDS Study, the youth in this study believed that STDs were of little concern, because treatment required only a quick visit to the local clinic. Although diagnosis of an STD was seen as an embarrassing situation, becoming pregnant or impregnating your girlfriend was seen as a stressful, morally-laden complication. Even though pregnancy was perceived as being a life-altering occurrence, most youth interviewed said that they would parent or put their child up for adoption rather than have an abortion.

Two themes emerged from the discussion concerning pregnancy. The first theme, identified from this data, was entitled *Becoming Pregnant*. In this study none of the adolescents had planned to become pregnant, yet five participants were dealing with the consequences of pregnancy. This sample is inconsistent with the Steven-Simons et al. (1996) study that claimed that young females are excited by pregnancy because it gives them someone to love and nurture who will give unconditional love in return. Klein (1998) reported that other studies have found that an adolescent pregnancy attracts much desired attention from family and friends and may be perceived as a means of holding onto a partner.

This last finding rang true for two of the participants. Katy did not want to become pregnant, but she knew her boyfriend would be upset if she terminated her pregnancy. In this particular case the male valued the pregnancy as a sign of his virility, and the female complied in hopes of making the relationship stronger. Kelty found that when she told her mother she was pregnant, attention shifted from her older sister as her mother became increasingly excited about the arrival of her first grandchild. Three cases of pregnancy in this sample resulted from a long-standing relationship between the parents at the time of conception. This is consistent with the findings of numerous studies which show that teen pregnancy is not typically the consequence of a casual fleeting relationship (Black & DeBlassie, 1985). More often the mother and father have known each other for at least one year, and strong feelings were present before sexual relations began (Black & DeBlassie, 1985). Similar to other findings, all parents in this study came from similar socioeconomic backgrounds and had achieved the same level of schooling.

The emotions related to becoming pregnant included feeling scared, stupid, and stressed-out over future life directions. Finishing school and obtaining employment in order to support the upcoming child factored heavily in these teens' minds. All four young mothers were forced to drop out of school to look after their babies. Two had plans to return to a reduced courseload, one intended to finish her diploma through correspondence, and one was unsure what would happen; she was in her ninth month at the time of the interview. Unfortunately, the statistics are against these teens, because 50% of school-aged parents do not graduate, thus inhibiting their ability to compete in the job market (Black & DeBlassie, 1985; Steven-Simons et al., 1996).

A second theme identified was entitled *What If?* . . . The five never pregnant teens suggested that if such an unpredicted event should occur, their first thought would be to parent the child. The differences in female and male responsibilities were also addressed in this study but to date have been given little attention in the published literature. Both genders in this sample recognized the ease with which adolescent males can shirk their responsibilities as fathers. Although it was the intent of the six males interviewed to remain devoted to their child, the parenting teens in this research attested to the fact that such promises are not often kept. The males felt that the attitude of the mother and the female's parents, and the financial situation would be factors in their ability to parent their children effectively. In one study, Spingarn and DuRant (1996) found that high-school-aged male youth who had impregnated their girlfriends reported significantly higher frequencies of health risk and problem behaviors then those who did not face pregnancy. These findings are consistent with the findings of this study.

Compared to 40 years ago when the majority of teen pregnancies resulted in adoption (Resnick, 1992), today's youth could not envision carrying a baby to term and then giving it away to strangers. Garbarino (1985) suggested that this belief was in keeping with adolescents' inability to think through decisions to the long term. Resnick (1992) wrote that educational aspirations, school performance, economic status, and internalized locus of control were again relevant factors in the decision to parent, adopt, or abort.

With regards to the abortion debate, six respondents were in favor of the procedure, yet had serious doubts as to whether they would be able to follow through with that option. Abortion became the subject of a spirited debate during the interviews. Five teens were vehemently opposed to abortion in any situation, calling the procedure an act of murder. Those who were receptive to the idea cited economic stability, educational attainment, marriage, and increased maturity as goals for raising a child. Falling short of these criteria, abortion was preferred to raising a child in poverty and perpetuating a cycle of neglect and unhappiness.

STDs and HIV

Four of the ten participants reported that the risk of STDs and HIV was the primary concern of sexual activity. The Canada Youth and AIDS Study (King et al., 1988) reported that 4% of the youth surveyed chose STD as a risk, rising to 8.5% for school dropouts. As previously mentioned, although youth realized the existence of STDs, they either were not convinced that they were personally at risk or believed the steps necessary to become cured were minimal. The youth interviewed felt that they had good working knowledge of the types and modes of transmission of STDs. Despite this knowledge, they did not seem to understand the magnitude of the problem of these diseases for youth, which is consistent with other studies (Betz, 1998; Biro, 1995; Imperato, 1996; Krowchuk, 1998; Lappa, 1998; Maxwell, 1994). There is some concern that Canadian adolescents may be putting themselves at unnecessary risk of STD by choosing the oral contraceptive pill (OCP) and/or withdrawal for the prevention of pregnancy while remaining at risk of acquiring an STD through unprotected sex (Health Canada, 1998). This was a problem for all the teens in the sample who relied on the unwavering monogamy of their partners. As partners got to know each other and felt comfortable, they were more likely to experiment with "feeling," discontinuing condom use and switching to OCPs or withdrawal.

The failure of today's youth to perceive STD infection as a serious threat is likely due to a decreased emphasis on STD prevalence with an increased focus on HIV/AIDS education. HIV/AIDS was rarely cited as a risk factor because it is not often that one hears about heterosexual teens becoming infected if they are not hemophiliacs, intravenous drug users, or prostitutes. The impact of HIV/AIDS once it affects someone in their immediate peer group is substantial. Keith was told to suspect that one of his past girlfriends had been HIV positive. A negative HIV test was enough to convince him that he had better be careful and modify his behavior. Although there is a quick fix for STDs, it is well known that AIDS is a guaranteed death sentence.

Emotional Peril

Limited literature exists which addresses the emotional risk of adolescent sexual involvement. Two participants in this study described this as a factor pertaining to relationships and to the negative outcomes of sexual activity. For example, Kurt felt that an intense emotional commitment in a sexual relationship can cause pain if that union ends. Furthermore, Katy worried that she would never discover how to exist in a sexual relationship and still maintain her version of "self." Combined with Mitchell's (1992) theory of adolescents' need for attachment and relationships, a repeated series of failed sexual partnerships during the teen years could have a lasting impact on adult connections.

Self-Risk

Quadrel et al. (1993) suggested that self-risk is different from perceived general risk. Although most teens in this study had a clear idea of the most threatening general risks in existence, these same individuals were reluctant to label themselves as *at risk*. All teens in this sample—pregnant, parenting, and nonpregnant—felt that they took suitable precautions to prevent them from becoming a statistic. Although they admitted to inconsistent contraceptive use, they felt confident in their ability to chose a safe partner and avoid the acquisition of STDs and HIV. Pregnancy, a primary concern, was often left to fate. Of those adolescents who were pregnant or parenting, most explained having learned their lesson and that chances are that they would not be so careless twice. Being at risk was one thing; an accident was quite another. Others felt scared to become sexually active again because of past negative experiences.

Numerous studies have reported the risk indicators for adolescents today. Among these are young age, multiple partners, frequent unplanned sexual encounters, substance use, and unprotected sex (Hein, 1995; Herold, 1994; King et al., 1988; Poulin et al., 1997; Slonin- Nevo et al., 1995). Adolescents often engage in risky behaviors because they meet specific developmental needs that are not being met by other sources. For example, Spingarn and DuRant (1996) found that

> social acceptance by peers (e.g., smoking marijuana); establishing an autonomy from parents (e.g., early parenthood); repudiating norms and conventional authority (e.g., delinquency); or affirming maturity and acquiring a more adult

> status (e.g., becoming pregnant) may serve a positive function for the individual adolescent despite the negative health consequences" (p. 266)

Generally, the teens who participated in this research did not differ significantly from other teens in respect to educational views and sexual behavior, but by nature of their unstable upbringing and uncertain futures, they do face risks different from those of their counterparts who have more resources. The literature concurred that those who believe that their chances of attaining goals are slim simply give up and engage in more immediate pleasure-seeking activities (Slonim-Nevo, Auslander, and Ozawa, 1995). There is a need to identify these at-risk adolescents early because risk behavior can have an impact on all facets of the transition to adulthood.

Sexual Experience

The teenagers in this study had a collective wealth of experience with sex and its natural sequelae. The average age of first sexual experience in this sample was 15 years: 14.8 for males and 15.3 for females. This finding is congruent with past research studies involving adolescents, including the Canada Youth and AIDS Study, whereby many adolescents were beginning their sexual experiences by age 14 (King et al., 1988). Sawyer and Smith (1996) found that the mean age of initiation of intercourse varies greatly according to different studies: males 14.7 to 16.1 years, females 14.9 to 17.6 years. The teens interviewed in this study differed in opinion as to what percentage of their peers were sexually active. Whereas a range of 50-90% was reported, a mean value of 77% was recorded, with most activity reported to begin within the first year of high school. Likewise, in an earlier study Hayes (1987) found that by age 20, over 80% of males and 70% of females were sexually active. King et al.(1988) also observed an increase in sexual activity once students entered high school in that the percentage of teens who experienced first coitus doubled from Grade 9 to Grade 11.

King et al. (1988), Fletcher (1994), Edwards (1995), and others have traditionally focused on the occurrence and frequency of what are known as the central sexual behaviors (i.e., holding hands, deep kissing, petting, oral/anal/sexual intercourse). To the youth in this study, *sex* meant intercourse, but they also outlined four additional categories of sexual behaviors. These categories were the "cut-off" points between what was termed sex and what was in the realm of sexual behavior. Harmless behaviors were those that generally could not get one into trouble. Teens reported that a fear of consequences or the risk of going too far played a part in their decision-making processes and that, whenever possible, it was safer for them to stay with the harmless behaviors rather than advance to intercourse. Safe behaviors included anything from holding hands to kissing to petting, as long as the clothing stayed on and the intentions were made clear. Arousal or stimulation was a red flag that indicated when these so-called harmless behaviors might become something more. Both genders agreed that arousal/stimulation may factor more into male behavior patterns, leaving females with the choice of "going all the way" or "pulling the plug." Males were thought to be more likely to get caught up in the motion and let things "just happen," whereas it was felt that females tend to debate the pros and cons while still in the act. Feminists and family-planning counselors have long remarked that girls and women are all too rarely "swept away" by their own sexual desires. "These desires are suspect from the first tingle, questionable until proven safe, and frequently too expensive when evaluated within the larger cultural framework which poses the question: Is it really worth it" (Thompson, 1990, p. 342). Despite adverse reactions, Thompson reported that in her study the females frequently proceeded with intercourse, only to regret the decision later.

Intimacy was important to many of the respondents who felt that sexual behaviors should be private, one-on-one displays of affection. In this case the focus was on the context or mood rather than on the behavior per se. Although you might kiss your partner in public, behaviors would become sexual only when privacy was secured. Finally, the teens in this study mentioned the emotional component of sexual behavior, which is all too often omitted from discussions concerning adolescent sexuality. For example, Bingham and Crockett (1996) wrote that the psychosocial aspects of adolescent sexuality are not well understood. It is difficult to quantitatively measure emotional response accurately, and because most of the research is quantitative, the literature did not focus on this aspect of teen sexuality. By employing a qualitative approach in this study, the interviews provided teens with an opportunity to describe the kind of emotional attachment they required before any acts of a sexual nature could occur. In effect, the teens described the emotional differences between making love and having sex. They reported that a natural "cut-off" point evolved as one experimented with the other sexual behaviors, and it determined whether one invested in an emotional commitment and initiated intercourse.

Losing Your Virginity

> The transition in status involved in first sexual intercourse represents a change that is made only once during the lifetime of the individual. This change has considerable significance for the individual, as well as society, since first sexual intercourse not only influences one's self-concept, but also creates interpersonal changes and societal concerns. Some individuals perceive first intercourse as a step toward independence from parents and other authority figures, whereas others view first intercourse as a rite of passage to adulthood. (Darling et al., 1992, p. 98)

Most of the adolescents in this study said that they simply wanted to get their first sexual experience out of the way. This was true for all but two participants, who beat the statistics and waited until they were over 16 to experience first coitus. To these few, being in love and sharing that "special moment" with someone who was committed to you and understood your feelings was more important then losing your virginity. They suggested prolonging other behaviors such as kissing, petting, and oral stimulation before having intercourse. It is of note that these were the teens who had higher educational aspirations and concrete future goals. Teenagers who are struggling in school and have lower educational aspirations are more likely to have sex during adolescence than those faring better in school (Brooks-Gunn & Furstenberg, 1989). Bingham et al. (1996) reported that early initiators of sexual intercourse experience a psychosocial risk, including more problem behavior and substance use, disrupted family and parental relationships, and poor school performance. An examination of the literature related to the above factors seems to be contradictory when discussing the findings of this study. For example, the participants in this study had exposure to the above indicators long before any experimentation with sexual behavior occurred. In any case, the youth who did embrace the idea that sex was not just for adults are not alone in the world today. In considering North American adolescents, one must remember the strength of the sex drive and the power of peer-group norms, often fueled by the media, to intensify the need to have sex (Crosby, 1996).

Younger participants in this research who had more sexually active older siblings were more sexually active than were those whose siblings were virgins. For example, Karl and Kelty attested to the influence of their siblings, as Kelty admitted, on "going all the way" to catch up to her sister, and Karl repeatedly mentioned the influence of his two older brothers. White and DeBlassie (1992) discussed the power of the family to influence delayed or early experience with sexual intercourse. They wrote that older siblings can have an effect on younger children's sexual behavior. Their research also points to the consequences of single-parent families where increased sexual activity of adolescents parallels the rapid increase in the number of children raised by one parent. Hechtman (1989) reports that as divorce rates increase, many teenagers live in single-parent households. The mother's or father's renewed interest in dating and evident sexuality may further influence the adolescent to similar behavior. As previously explained, many of the teens in this research talked of coming from dysfunctional families plagued by instability and divorce. Katy's mother, for example, did not know the identity of Katy's father and had numerous relationships during Katy's childhood and early adolescence. Kelty was not a stranger to divorce; her parents split up when she was 11, and both initiated new relationships. Kyle did not mention his father but alluded to the frequent absence of his mother while he was younger. All of these teens reported early experimentation with intercourse.

The phenomenon of early-adolescent sexual experience was illuminated as the teens shared their stories. Katy's story represents a common one reported in the literature by young adolescent girls. As with others, her first time "just happened." She had no prior relationship with her first partner, and there was no planning involved in their spontaneous one-night stand. Because of this experience, Katy said that she had been unable to distinguish between sex and love. Now she used sex to show love and ultimately lost her self-control in every relationship. This lack of assertiveness and control is typical of the developmental level displayed by adolescents. The more females were afraid or viewed sex and love as fused, the less likely they were to use protection. Haffner (1998) reported that, contrary to popular beliefs, fear does not stop sex; it just leads to being more "swept away" with all its tragic sequels. In addition, Sawyer and Smith (1996) suggested that females are more likely to be involved in a dating relationship, consider themselves to be "in love," feel pressured by their partner, and regret having intercourse in the first place. As Katy mentioned, many girls look back and wish they had not lost their virginity at that time.

Although patterns of sexual experience have become increasingly similar between males and females, there are some fundamental differences in response to losing their virginity. Females are more likely to label sexual relationships as love, are less likely to view sex as pleasurable, and are increasingly likely to bear the brunt of negative outcomes (Hechtman, 1989). Whereas females are more apt to make their sexual debut in a committed relationship, males take an often-casual approach to their virginity (Darling et al., 1992). Like Katy's, Kyle's first sexual experience "just happened." Kyle was in a casual relationship with a partner who was older and more sexually experienced. He described the experience as awkward, embarrassing, and disappointing. Kyle's less than exhilarating encounter with intercourse prompted him to wait more than a year to experiment with sex again. Although movies and TV depict sex as an amazing, ground-shaking activity, it was not the experience of the majority of this sample. This finding is congruent with the literature that suggested that even though the age of teen initiation of sexual activity has decreased, this does not necessarily mean that youth will continue to have sex constantly throughout their teen years. Brooks-Gunn and Furstenberg (1989) wrote that is not uncommon for a teen to have first intercourse at age 14 or 15 and then not to have sexual relations again for a year or two. Thompson (1990) labeled this act as "post-coital reform," a waiting time for return of desire and a more suitable partner.

The letdown that so many teens experience is not wholly physical; it is romantic as well. Girls often expect that having sex will transform an uneven relationship into a blissful fusion or transform their lover into a devotee. Although the literature did not often comment on the male experience of sexual debut, both sexes lament over the disappointment that pervaded their memory of first coitus. Context and emotions were two themes which emerged from discussions encompassing lost virginity.

Context. The adolescent participants reported that they experienced everything from sex in a committed, long-term, monogamous relationship to incredibly short-lived flings and one-night stands. Substance use factored into the first-time sexual encounters recounted by some teens in this study. As reported previously, 3 of the ten youth reported using alcohol prior to their first time, and two admitted to being stoned or high. There are those who claim that being stoned, high, or drunk leads one to become sexually active as one risk behavior perpetuates another. Others suggest that youth indulge in substance use in order to reduce inhibitions and allow teens to have intercourse, free from self-consciousness (Cohn et al., 1995; Dryfoos, 1990; Luster & Small, 1994; Melzer-Lange, 1998; Quadrel et al., 1993). Donald et al. (1995) believed that substance use may be gender related in that males have sex because they indulge, whereas females indulge in order to have sex.

Emotions. The youth collectively described their first coital experiences as horrible, stupid, lousy, nerve-wracking, embarrassing, painful, scary, and good. Sawyer and Smith (1996) discussed similar experiences of their sample of 332 first-year college students when they described their first intercourse. Responses ranged from extremely positive (euphoric, perfect) to extremely negative (horrifying, painful). A more general scope included responses that ranged from good and fun to awkward and uncomfortable. Donald et al. (1995) found that females were more likely to report feeling fear, guilt, anxiety, and embarrassment; whereas males were more likely to claim excitement, satisfaction, and joy. The females who participated in this study tended to report pleasure if they perceived their male partner as gentle, loving, and considerate, as in Karen's situation, where she felt that she had indeed saved sex for the person she was going to marry, and thus did not regret her actions. Donald et al. reported similar findings: Girls who had engaged in alcohol or drug consumption preceding sexual intercourse often experienced negative emotions and regretted having sex. Furthermore, few boys said they felt used or "bad" after sex and partying.

Guilt, doubt, and the pain of feeling used are all common psychological risks of adolescent sexual involvement (White & DeBlassie, 1992). Moreover, in this research the teens commented that they did not really know what they wanted from sex, they thought they were ready, and they wished that others would realize what they were getting themselves into by becoming involved sexually. It was difficult finding other qualitative studies regarding adolescent sexuality. Furthermore, limited research of first coital experience should be a concern for youth educators and health practitioners (Sawyer & Smith, 1996). As well, Donald et al. (1995) admitted that few studies have examined young people's emotional reactions to intercourse and the links between these responses, gender, and the context of sexual experiences.

Condoms and Contraception

The literature reminded us that one of the fundamental problems of teen sex today is a lack of consistent contraceptive use. This sample did not differ from published studies in respect to the methods and reliable use of safer sex techniques. However, interviewing enabled the participants in this study to discuss underlying reasons for condom use and nonuse, which is not frequently reported in the literature. The ten participants identified four major themes that describe the competing factors behind contraceptive use among teens.

The findings from this research revealed that "protecting myself" and "taking chances" emerged as themes when the teens were explaining the effect of condoms and other contraceptives on their sexual relationships. Almost all respondents who considered condoms to be important in protection from pregnancy and disease acknowledged inconsistent usage. Similarly, Brooks-Gunn and Furstenberg (1989) found that about one half of all teenagers in their study did not use contraceptives the first time they had sexual relations, and younger adolescents are much less likely to use contraceptives than older adolescents. The teens in this sample appeared to be proud that their first sexual encounter was protected; it was subsequent sexual experiences that became a problem. Most younger adolescents are not developmentally ready for the responsibility required to be effective contraceptive users (White & DeBlassie, 1992). This was recognized by more than one teen in the study; therefore adolescents are not ignorant of the factors underlying their behaviors, but, more accurately, they fail to understand how the factors can be modified. The problem with condoms and teens lies in their inability to communicate with their partners and to back up their beliefs with action, something several researchers have reported (Hechtman, 1989; Maxwell, Bastani, & Yan, 1995; Sawyer & Smith, 1996; Stevens-Simon et al., 1996). Condom use needs to be a joint decision between partners but is often left up to one or the other to suggest or initiate the discussion.

In light of previous research by Brooks-Gunn and Furstenberg (1989) and Campbell and Campbell (1990) which claimed that the majority of teen sexual encounters "just happen" without forethought or planning, it is not surprising that couples do not discuss condoms prior to sexual activity. To use or be prepared with condoms is to admit that one plans to be sexually active. Younger teens do not think about the long term and especially do not want to be caught buying or possessing such items as condoms and other birth control. The notion of taking action now in order to increase the probability of prevention and desirable consequences in the future is an abstract concept to teenagers (Campbell & Campbell, 1990). Kent was an example of a teen who consistently used condoms. He could be seen as an anomaly within the confines of this study. Although he possessed a classic "at-risk" profile (poor educational attainment, broken family unit, substance abuse, gang activity, and delinquent behavior), he claimed to be adamant about condom use. He explained that one cannot always trust that a partner is clean or on the pill. He took the responsibility of carrying condoms with him and refused to engage in any activities unless he was protected. Kent did not want to become a father or an AIDS fatality.

The third theme addressed by the participants was entitled "initiating responsibility." Although Hechtman (1989) claimed that the responsibility of contraception lies with the female, this sample was equally divided on who ultimately initiates safer sex. Of those who used a method, male methods seemed to be the overwhelming choice as reported by both males and females. This finding showing condoms and withdrawal to be the most popular methods is consistent with other studies (Brooks-Gunn & Furstenberg, 1989). Moreover, Bowd and Loos (1995) have completed numerous studies on the topic of contraception, and they concluded that women are more susceptible to heterosexual transmission of HIV and STDs than males. They noted that inadequate partner communication, female unwillingness to refuse risky sex, and the guard letdown that wills some into thinking that they remain a part of a monogamous relationship were common explanations. These researchers made additional observations. They noted that continuing acceptance of "the traditional role assigning women the primary responsibility for avoiding pregnancy must be balanced with the promotion of males to carry condoms to avoid STDs" (p. 25).

Another theme that emerged from the findings was "condoms vs. other methods of contraception." Most of the teens in this sample believed that birth control was too inconvenient because they had to go to special clinics to obtain free supplies. The timing of the intake of the pills discouraged teens and did not seem to mesh with their hectic schedules. As Katy said, "I am late for every appointment I ever make. How can I get myself to take a pill at the same time every day?" Most girls, however, found it especially difficult to persuade themselves to go to the clinic to obtain a prescription. As noted in a previous section, the reason for this behavior could relate to ownership of action by admitting that one is sexually active, and not wanting to be "found out." In speaking with other youth, it appeared that the birth control pill was far more prevalent among more affluent teens than among those from a lower income bracket. In any case, participants in this research study disagreed with current statistics, which found that the oral contraceptive pill (OCP) had overtaken the condom as the contraceptive of choice (Health Canada, 1998). The most common method of birth control in this sample was the withdrawal or rhythm method. Again there is a lack of literature describing these methods of contraception and the reasons for their choice. The teens stated that withdrawal, although admittedly not the safest method of contraception, increased the "feeling" from sex and was more suitable for couples allergic to latex or experiencing the negative side effects of the pill. "Feeling" during sex was rated very high among the teens and resulted in a dislike for condoms. Ultimately, the adolescents said that they were convinced that their monogamous relationships protected them from STDs; thus, timing for pregnancy was their chief concern.

Finally, abstinence was discussed during the interviews but quickly dismissed as a reasonable option for today's teens. This view was supported by the following quotation from Campbell and Campbell (1990): "In the context of the Ford Edsel automobile, it is probably fair to say that abstinence is the Edsel of sex education today" (p. 191). When the participants were asked to describe why they delayed engaging in their first sexual experience, the responses were remarkably similar to those found in the adolescent sexual health literature. The teens in this study listed five main reasons for abstaining from sex in the past: They were waiting for the right person, they were not being ready yet, they had no interest in sex yet, the circumstances were wrong, and sex was against their religious beliefs. Sawyer and Smith (1996) studied the reasons stated by teens throughout the literature when preparing for their study on first-time intercourse, and they identified similar reasons. For example, their top four reasons to abstain included not having met the right person, waiting until marriage, lack of opportunity, and religious beliefs. The message of abstinence can be a difficult one to accept, particularly when competing with the glamorous image of sex as portrayed by the popular media (Sawyer & Smith, 1996).

Although the findings of this study show that contraceptive use by teens is inconsistent, it is insufficient to leave this statement in isolation. Health practitioners and promoters need to understand adolescent reasoning in order to improve services and availability so that condoms and birth control pills will be the only realistic choices. Even though the literature reported that teens do at times rely on condoms, they will not necessarily continue to do so consistently. We must probe to discover and understand the conditions, which favor condom use and why these behavior patterns break down. If delaying intercourse and increasing condom use are the two focal strategic maneuvers that teens use to protect themselves today, then we cannot be satisfied with repeated statistical revues on adolescent contraceptive use.

Sex and Relationships

A major theme that emerged from the findings on adolescent sexuality and previous sexual experience centered around ideas of what constitutes adolescent heterosexual relationships and how sex fits into and influences these partnerships. Mitchell (1992) believed that all teens go through a stage characterized by narcissism and that nowhere are its effects more profound than in the friendships, relationships, and romantic involvement of teens. He added that youth have a strong desire to obtain friendship and companionship, yet they hold expectations of giving and receiving that inevitably lead to dissatisfaction. For example, he noted that a common scenario plagues male/female unions during the adolescent years. Males are driven by the need to appear "cool" or "men" amongst their friends, whereas females seek self-gratification from the attention they receive from others.

> At the beginning of the relationship the boy praises, pursues and woos the girl with an earnest aggressiveness. The girls, with stunning consistency, perceive these actions as 'love,' or some such lofty experience, whereas 'eroticized fascination' usually describes the relationship more honestly. The girl perceives the boy's persistence as an interest in her and even though they 'know' that love is not what is happening, they still will not admit this to themselves. Their assessment of the relationship is elevated by their egocentrism. (p. 75)

Whereas Mitchell (1992) takes a rather cynical view of teen relationships, White and DeBlassie (1992) suggested that adolescent relationships fulfill a desire for attention and affection, bolster self-esteem, ease loneliness, offer an escape from boredom, and confirm their masculinity or femininity. Furthermore, Brooks-Gunn and Furstenberg (1989) found that adolescents may engage in sexual relationships for many different reasons, including (a) as an effort to achieve what seems to be unavailable goals, (b) as a way of coping with personal frustrations and anticipated failure, (c) as an expression of opposition to conventional society, and (d) as membership in the peers' subculture. These points should not be lost in our discussion of adolescent relationships, for it is the primal act of praise and flattery that forges and sustains many teen alliances.

Indeed this has been the case with many of the teens in this study. Some of the females admitted to falling head over heels in love with the males to whom they lost their virginity. For instance, Kelly dated her boyfriend for three years before having sex. Furthermore, Kelty thought her one-year relationship would support sexual intercourse but has since realized that love was not a reality when she decided to have sex. Moreover, Katy has never been able to distinguish sexual relationships from love. Finally, Karen believed that she had fallen in love with the boy she would eventually marry; but recent events (post-data collection) have led to their break-up, Karen is now madly in love with a new beau, and the cycle continues. This kind of emotional sacrifice was not exclusive to the female respondents. Although three out of six males in the study resembled the stereotype that Mitchell (1992) described, the other males wanted to find love every bit as much as the girls. For example, Kyle thought that his first time would be memorable. When this was no so, Kyle was prompted to abstain until he met the right girl. Kurt delayed intercourse until he was 18 in order to attempt to find "true love."

Adolescent relationships embrace honesty, respect, and openness as desirable qualities. The teens in this study agreed that in most cases sex simply added more stress to the union and was not necessarily a good thing. A disturbing factor of sexual initiation was the perpetuation of sexual behaviors in subsequent relationships. For example, Kelty and Kurt were both at a loss to justify abstinence because they had already engaged in sex. They said that they experienced the pressures, both partner- and self-generated, of sexual expectations.

Scholars such as Mitchell (1992) may scoff at the foundations of adolescent relationships, but those who work with youth should not underestimate the intensity of commitment of the self and emotions in these couples. Adults all too often dismiss teen relationships as "puppy love" or "crushes," but more may be going on beneath the surface that can have lasting effects on future adult relationships. The adolescents' perceived reality is a powerful force that should not be taken lightly (Brooks-Gunn & Furstenberg, 1989).

A Framework of Adolescent Sexual Behaviour and Sexual Risk

The purpose of this study was to describe the underlying issues and concerns of today's youth regarding their sexual behaviours and their risk of the negative outcomes of sexual activity. As a result of the findings from interviews with ten unique individuals, the researcher was able to develop a framework of adolescent sexual behaviour and sexual risk based on the adolescent's perspectives. Four major components were reported to have a direct effect on adolescent sexual activity and the initiation of sexual intercourse. These components, described in Chapter IV, are age, education, motivation, and perception.

The first determinant of sexual activity identified by this research was age. At an unspecified stage of adolescent development, thoughts of sexuality begin to figure prominently in the lives of youth (Moore & Rosenthal, 1993). This stage is not bound by developmental laws but begins at different times for each individual and may be a product of actual/physical age or an assumed maturity level due to prior life experiences.

Initially the youth question their developing feelings and how these thoughts fit into their current models of behavior. They contemplate the idea of becoming sexually active, but at this time no activity occurs. Sexuality education begins to play a dominant role, especially for those youth who are exposed to extensive media outlets and those in junior and senior high school where sexual health education programs are launched. A period of knowledge acquisition and synthesis occurs, with information coming from all directions and from a variety of sources. Attempts are made to make sense of the competing avenues of information. Storytelling and confirmation is a process whereby teens can test out beliefs and proposed actions with peers, siblings, parents, and trusted others. These confidants may or may not be able to share experiences or trustworthy advice.

Motivational factors play a large role, and their significance determines whether the youth will become sexually active. The motivational factors identified by the teens in this study are but a few of the many that may influence teen decision-making processes.

Finally, the degree of experimentation is determined by the perceptions of adolescent sexuality as a whole. Perception may include a variety of beliefs such as the extent of friends' sexual activity or the idea that sex is necessary to maintain their relationships. Decisions can take the direction of abstinence or intercourse. Abstinence means refraining from intercourse, but not necessarily from all sexual activity.

Adolescents may travel down this pathway many times experimenting with different choices and outcomes as the parameters change. One common finding in this study, however, was that teens who engage in intercourse seem to "fast-track" the pathway in subsequent relationships. This was seen as a problem for most adolescent participants because they felt that once one has sex, it is expected (both partner- and self-inflicted) that one will engage in intercourse again. Other teens felt that if one decided to change one's mind after initial intercourse, it was possible to go through the pathway and emerge on the opposite side. This framework was designed to show the numerous factors that adolescents identified which influence decisions regarding sexual activity.

CHAPTER VI

CONCLUSIONS

> The ambitious climb high and perilous stairs, and never care how to come down; the desire of rising hath swallowed up their fear of a fall. (Thomas Adams)

Concern for the health of adolescents is not a new phenomenon, yet the topic of the adolescent sexual experience requires more attention than it has received. There are many challenges in the development of today's youth that require adjustments by both adolescents themselves and society which strive to support this development. With the continuing trend towards early-adolescent sexual activity, efforts have been made to decrease the exposure to negative outcomes, such as STD/HIV transmission and teen pregnancy. The majority of studies and the resulting strategies designed to reduce these risks have focused on knowledge acquisition largely in regards to consistent contraceptive use and/or the delaying of sexual experimentation. The youth in this study outlined the many factors impacting their decision to become sexually active. Few other studies have attempted to identify such influencing factors from the perspective of the adolescents and, more important, in their own words.

The adolescents in this study were more than willing to share their perceptions and experiences in regards to sexual activity. Through the interviews the teens described their unique stories and perspectives of the factors influencing adolescent sexual decision making. This particular group of teens had a wealth of life experiences to offer, usually stemming from a history of family dysfunction and general instability. Clearly identified in these youth's accounts of their lives were the strong influence of family, friends, school, and the media. Pregnancy was the number one concern of risky sexual experimentation, with STDs and HIV/AIDS placing a distant second and third. The emotional risk of sexual intercourse was a subject that was reinforced on numerous occasions and is a subject which has received minimal discussion in the literature to date.

Review of the Research Methods

An exploratory, descriptive study was used to compose a framework of the factors influencing adolescent sexual activity and sexual risk behaviour. This study focused on the experiences of a small group of adolescents from an urban youth agency. Data collected from one-on-one interviews with the adolescents were analyzed and used to explore, describe, and answer the research question. The analysis was completed using the principles of ethnography, combined with a content analysis approach.

Strengths

A significant strength of this study was the flexible nature of the open-ended line of questioning employed in the interview. The participants were free to take their own directions, because the structure did not force them to reveal personal information; rather, it allowed them to tell their stories in their own way.

The second strength was that a variety of experiences were obtained from one sampling location. The characteristics of this sample were diverse in terms of background, socioeconomic class, and sexual experience. This study addressed needs and concerns and sought the experiences of a group of adolescents who are not often given a voice in studies of sexuality: the disadvantaged.

The third strength of this study was the rapport established between the researcher and the study participants. The participants were made more comfortable knowing that the interviews were conducted on their own "turf." In addition, the informal conversational style of the interviews encouraged open and honest disclosure. More than one interviewee thanked the researcher for doing the study and felt that it gave them the opportunity to voice their opinions and think about their actions. For example, Kent revealed that, when asked to do the interview, his initial reaction was to "just say no." On second thought, he decided to attend for five minutes and bolt "if the questions sucked." This particular interview lasted for over an hour. Kurt shared his evaluation of the interview process: "I can honestly say, I think that this is a good thing. Making people talk about [sexuality], in a one-on-one thing, making them think about things, this is definitely a good thing."

Limitations

The sample with ten participants was a purposeful sample: The participants were recruited based on eligibility criteria (15 to 19 years old, from the Edmonton area, and fluent in the English language) and a willingness to be interviewed. The teens in this sample were all part of an independent living program and thus may not have been representative of disadvantaged youth in general. The diversity in experience and contextual data could help others assess whether these findings would apply to similar diverse groups. Finally, selection bias may have been a factor because the program director was in charge of sampling and inclusion, and thus potential candidates may have been excluded from the study due to a personal bias.

Implications and Recommendations

The findings of this study have a number of practical implications. They are as follows.

1. Pregnancy rates and STD/HIV transmission continue to be a problem for adolescents; as such, we must conclude that knowledge is not enough to change behavior. The tenets of health promotion suggest that prevention education can help to improve the health of youth. Adolescents today need training to enhance interpersonal skills and develop motivational strategies for safer sex. Training should focus on and include interactive sexual communication skills for use with a potential partner, such as assertiveness skills to increase condom use; negotiation skills and conflict avoidance to help delay sexual initiation and unsafe sex; and refusal skills to combat social, media,

and negative peer pressure. Intimacy issues, sexual limit setting, and pregnancy/STD prevention should also be included.

2. Sexuality education classes should be redesigned to include the perceived needs and interests of the youths as well as the standardized topics of sexual health information. From a health promotion perspective, these perceived needs will vary based on the background, socioeconomic status, and prior sexual experience of the various participating adolescents; and the focus and topics covered should reflect these differences. A universal model of healthy sex education is not the most efficient or effective strategy. Short-term, concrete aspects of sexual behavior and its consequences should be emphasized, as adolescents have difficulty thinking out consequences of actions into the future. Youth education programs must ensure that educators have an interest and special training or experience in working with teens. Programs should be offered at hours and locations convenient to the target group. Youth, parents and school system personnel should be involved at all phases of program design, implementation, and evaluation.

3. School sexuality programs should address the decision-making process of teens with practical skills. Role playing, problem solving, and small-group discussions are ways to build confidence in teens, although they require that adequate time be slated for these activities.

4. We must recognize that "at-risk" populations of youth more frequently encounter the negative outcomes of disease acquisition and pregnancy. It is also more likely that these adolescents will have poor relationships with their parents and will not attend school regularly and thus miss out on sexual health education. Community agencies and outreach centers must cooperate with health-promotion professionals to find additional ways to engage these youths in programs that relay sexuality information and skill development. Identifying how this would proceed involves inviting adolescents

to be a part of the planning process and including them in the decision-making periods of development, implementation, and evaluation.

5. "At-risk" populations require additional tools to encourage them to envision a plan for their lives. All too often these youth become stuck in a sense of hopelessness and view poverty, stress, and loneliness as a natural part of life. Health promoters take a holistic approach to program design, acknowledging diversity and paying attention to all the determinants of health. Financial planning, educational attainment, and relationship building are part of the determinants that can reduce risk behavior. Adolescents need to understand the reasoning behind their sexual activity and the means of avoiding unsafe conditions.

6. Those involved in working with youth should be aware that early initiation of smoking, alcohol, and drug use are all indicators that correlate with premature sexual activity. Youth who present with any of the above should be included in discussions regarding sexual activity, because skill development in one area can cross over and affect many levels of adolescent experimentation. Health-care providers, practitioners, and educators should develop interviewing skills to be able to assess adolescents adequately for these risk factors.

7. Evaluation strategies should be built into all program models, with key stakeholders, objectives, and success indicators established prior to program design and implementation. Only when comprehensive evaluation reports exist can more effective programs be introduced and shared for the benefit of targeted populations.

8. Abstinence as a primary goal of adolescent sexuality messages is not an inclusive concept. At this time there exists a high approval rate for sex before marriage, and campaigns that focus on numerous limitations and negative messages will fail because teens "tune out." What is needed is a social marketing approach that increases teen input into message design.

Suggestions for Future Research

This study provided useful information about a group of "at-risk" adolescents in a large urban center. There continues to be a need for additional research with this population and in regards to adolescent sexuality as a whole. The exploratory nature of this study has stimulated ideas for future research.

1. More qualitative research is needed because research on adolescent sexual behavior has generally focused on whether or not teens are sexually active and with what frequency. The answers to these questions are now available; thus the time has come to examine more closely the underlying factors influencing adolescent sexuality. The publication of qualitative studies should increase to supplement the numerous survey-type studies in existence with more in-depth information.

2. The phenomenon of "teen invulnerability" should continue to be researched. Qualitative studies portraying adolescent perspectives of vulnerability would be more beneficial than quantitative studies when attempting to flesh out the thought processes of teenagers in the area of risk taking. The relation between perceived vulnerability and precautionary behavior is a central component of virtually all current models of health-protective behavior.

3. Emotional risk is another concept that has been given little attention to date in adolescent literature. More information about the emotional costs to first-time coitus, condom use, teen pregnancy, and sexually transmitted diseases would be helpful to educators who work with youth.

4. Qualitative studies of parent-teen communication patterns would be useful to discover how early initiation of "sex talks" impacts future sexual behavior. In addition, it would be valuable to learn when these talks occur, in what context, in how much detail, and how successes and failures are determined.

5. Qualitative studies that outline the male perspective of sexuality are lacking. Of the few qualitative studies completed on intimate aspects of teen sexuality, the male

perspective is rarely reported. Useful information would include opinions of contraceptive use and responsibility, the emotional reactions to sex and relationships, the impact of family and friends on decision making, and the pros and cons of current sex-education classes and educators.

6. The 1988 Canada Youth and AIDS Study should be updated. Canadian studies of widespread adolescent activity are few and far between, and the information available is frequently outdated.

7. Longitudinal studies are needed to determine whether perceptions of vulnerability predict subsequent precautionary behavior and whether changes in risk perceptions predict changes in behavior. These studies would be most applicable to future program design and the basis for evaluation indicators.

Adolescents and Health Promotion

What is health promotion? The World Health Organization (WHO) and others have defined *health promotion* as a process of enabling individuals and communities to increase control over the determinants of their health (Wallerstein, 1992). Health promotion seeks to shift the emphasis from treating disease to improving health and healthy decision making. Promoters of this discipline try to ensure that there are opportunities for the voices of all of society—the poor, the elderly, the young, the disabled, and so on—to express their concerns. Health promotion comprises efforts to enhance positive health and reduce the risk of ill health through overlapping spheres of health education, prevention, and health protection (Downie, Tannahill, & Tannahill, 1996). Preventing illness and disease has to do with one's social and physical environment and how one behaves in these environments (Canadian Public Health Association, 1996a). This realization has been accompanied by the idea that educational efforts to change policy and behavior currently constitute our best chance of promoting health.

How does this study on the perceptions of adolescent sexuality relate to health promotion? Adolescents are often considered a challenging and exceptional population in which to promote health and healthy lifestyles (Petosa, 1986). As shown in this research, teenagers experiment with a wide range of behaviors, many of which predispose adolescents to disease, pregnancy, and certain negative social consequences. However, Gillis (1995) noted that adolescents are extraordinarily receptive to information about themselves and their bodies. This finding provides an excellent opportunity to address the risks of pregnancy, HIV/AIDS, and STDs, and the socioeconomic factors interacting with and impacting on teen decision making. Health promotion stresses the need to assess the multitude of factors that interplay to increase adolescents' risks of acquiring an undesirable outcome related to sexuality. Health promotion speaks to health issues in context and supports a holistic approach, which requires a long-term perspective (Canadian Public Health Association, 1996b). This study is especially geared to two of the five target areas for health promotion as defined by the Ottawa Charter on Health Promotion (World Health Organization, 1986): First, the ability to create supportive environments through rapport building and dialogue with community agencies, schools, and families; and second, helping teens to develop personal skills in the direction of health-promoting behavior are tenets of the Charter. Adolescent sexuality fits into the Framework of Health Promotion (Epp, 1986). The principles behind this framework encourage healthy life choices while reducing preventable illness, injury, and death. In regards to adolescent health, the challenge lies in increasing preventative behaviors such as condom use and delayed sexual activity. The mechanism directing health promotion in this case is self-care, which focuses on the decisions and actions that individuals take in the interest of their own health. Finally, in implementing strategies to address the issues discovered, strengthening of the community schools, services, and agencies is required.

Improving health and quality of life is a major goal of adolescent health promotion (Gillis, 1995). As evidenced by the literature review and findings of this study, youth today face a number of detrimental outcomes that arise from sexual experimentation and other health-compromising behaviors. Adolescence is a key time period to intervene with health-promotion strategies before damaging behaviors occur and before set patterns of behavior develop. Throughout this document the collection of adolescents' perspectives regarding their needs and concerns has been stressed as crucial to developing a better understanding of adolescent sexuality. Health promotion is geared to this work because it strives to take into account client assessments, the continued participation of target groups in the programs, and strategies designed to address these needs and concerns. The adolescents are viewed as valuable resources, not obstacles. Successful health-promotion efforts provide an opportunity to capitalize on the adolescent's desire for independence in decision making and encourages ownership and participation in the developed programs (Gillis, 1995).

At this time there is much to be done in the field of adolescent health promotion. The partnership between qualitative and quantitative research and program development can make measurable inroads during this transitional stage known as adolescence. Effective health promotion will require the support of many individuals, professionals, institutions, agencies, and, most important, the adolescents themselves.

Summary

The need for acknowledging the perspective of adolescents and utilizing these perspectives to enhance, promote, and protect the health of adolescents cannot be overstated. The participants who were kind and generous enough to share their beliefs and experiences were providers of more information than could be found hidden in theories and hypotheses. The presence of 12 witnesses on the subject of adolescent sexual activity allowed the researcher to learn first hand the factors that influence adolescent day-to-day decision making. Continued research with this focus can only benefit the all-encompassing area of adolescent health promotion. Not only was the opportunity to undertake this research beneficial to the researcher; but, more important, the experience was also seen as positive and enlightening to the participants themselves.

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APPENDIX A

PRE-INTERVIEW DEMOGRAPHIC QUESTIONS

Thanks for volunteering to be a part of this study. I am conducting this research to find out about young people's perceptions of sexual behavior and sexual risk so that we may be able to develop effective educational programs and materials.

First of all, I need to know a few things about the people I am interviewing. I ask that you answer these questions by writing your answers beside the questions.

Information you give here and during our discussion will be anonymous. Your name will not appear connected to your information. There is no way that your friends, family, or anyone else you know can find out what you wrote or what you say. You don't have to answer any questions that you find too private, and if you feel too uncomfortable, you can withdraw from the session at any time.

1. Are you male or female? Male ________ Female ________

2. When were you born (year/month)? ________

3. Are you currently attending school? ________

4. If yes, what was your average mark last term? ________

5. How far do you intend to go in further education (e.g., college/university, technical school, diploma/degree)?
____

6. What career goals do you have in mind at present? ________________________

7. Do you have a job right now? Yes ________ No ________

8. If so, what do you do? ____________________________________
____

9. How many hours a week do you work? ______________________________

10. Who do you live with now (family situation)?
____

11. Where were your parents born? Mother______________________
Father______________________

12. What do your parents do for a living?
Mother____________________

Father____________________

13. What kind of relationship do you have with your parents, brothers/sisters?

____

____

____

14. What kinds of things do you do in your spare time?

____

____

____

____

15. Do you smoke? Yes ________ No ________

If yes, how may cigarettes do you usually smoke in a day? __________

16. Do you drink alcoholic beverages? Yes ________ No ________

If yes, how often? ______________________

17. Do you use drugs? Yes__________ No__________

If yes, which ones? ______________________________

How often? ______________________________

18. Do you consider yourself a religious person? Yes ________ No ________

If so, of what religion are you? ______________________________

APPENDIX B

INTERVIEW PROTOCOL

Introduction: Thanks for coming today. I am conducting research to find out about young people's sexual behaviors and perceptions of sexual risk in order to help develop effective educational programs and materials. I am interested in what you think, so there are no right or wrong answers: I am interested in your honest opinions.

Remember that all the information you give will be recorded but kept confidential. This means that I have put a coded number on the tape to conceal your identity. There is no way that your friends, family, or anyone you know will be able to find out what you wrote or said. If you feel awkward about a question, let me know and you don't need to answer it. If you feel too uncomfortable during the interview, let me know and you can leave.

Feel free to ask questions at any time. Are you ready to start?

1. Background

   Family Background

   Composition

   Relationships

2. School Background

3. Future Plans

   In 10 to 15 years

4. Can you think of a movie, sitcom, or song that describes your life?

5. Can you tell me how you view health? What does "Health" mean to you? What does "health" look like to you?

6. Can you help to shed light on the behaviors of adolescents?

   How many teens today are sexually active (m/f)?

   How many teens today drink alcohol (m/f)?

   How many teens today do drugs (m/f)?

   How many teens smoke (m/f)?

7. What is your definition of *sexual behavior*?

How would you describe sexual behavior?

8. Are you sexually active?

9. How long have you been sexually active?

10. How many partners have you had since becoming sexually active?

For those who have been involved in sexual behaviors, ask questions A and B (skip C and D).

For those who have not been involved in sexual behaviors, ask questions C and D (skip A and B).

A. Can you describe your first sexual encounter? Describe your story in detail, like a diary entry.

Where did this happen and who was there?

When did this happen?

What happened?

How were you feeling at the time?

Why did you get involved?

B. Can you describe a situation where you were with someone and were expected to have intercourse but nothing happened?

Where has this happened and who was there?

When has this happened?

What happened?

What were you feeling at the time?

Why didn't you get involved?

C. Please describe those situations that you imagine might encourage you to become sexually active (ideal circumstances).

Where might this happen and who would be there?

What might happen?

What might your feelings be that you decide to become sexually active?

Why would you get involved?

D. Please describe situations that you have experienced or that you imagine might discourage you from deciding to be sexually active.

Where might this happen and who might be there?

What might happen?

What were your feelings or what might be your feeling that you become discouraged?

11. Sexual Health and Risk

A. General

Now that I know a little bit more about your sexual activity, I'd like to ask you some questions about the risks involved.

1. What do you see as the biggest risk involved/associated with having sex? Explain why this might be a problem.

2. Are there other risks involved/associated with having sex that you are aware of? Why might these be a problem?

3. What do you think about ad campaigns and educational messages that focus on abstinence and safer sex? Do you think that making people more aware of the risks would motivate them to change?

4. If you were in charge of designing a message/campaign to educate youth about the risks involved with sexual activity, what would you say to your peers?

B. Self

Now, I'd like you to think about the consequences of your own personal sexual activity.

1. Do you worry that anything bad might happen to you?

If Yes:

Why is this a worry for you?

Could you tell me more about that?

Did anything bad in the past happen?

If No:

Why do you think nothing bad will happen to you?

2. Do you know someone who has had a bad experience with sex?

3. There is lots of information available about the negative consequences of unprotected sex. Does any of this make a difference in the way you personally think about your own risk?

Why or why not

4. Discuss the saying, "Youth today think they are invincible."

5. What are your views on:

- sexually transmitted diseases
- HIV/AIDS
- Pregnancy
- abortion

6. What things do you do to make sure that nothing bad happens when you are having sex?

What precautions do you take?

What kind of contraception exists?

7. What do your friends say about your behavior?

Do they support your choice to be sexually active/not active?

How does your sexual behavior compare to that of your closest friends?

How influential are your friends on your behavior?

C. Education

1. What do you think your parents, peers, and society think you should do in relation to sexual activity and prevention behaviors?

- abstinence
- safer sex practices

- wait until marriage

2. How motivated are you to comply with these opinions?

3. How useful have the following information sources been to you with regards to sexual behaviors and safer sex?

   - school
   - parents
   - friends

4. How valuable are these resources to you?

5. Which was your most/least accurate source?

Conclusion

1. Is there anything you'd like to add to what you've said so far? Now is your chance to tell researchers anything you'd like about adolescents and sexual behaviors.

2. Would you like to clarify or elaborate on anything you have said in the interview?

3. Is there anything that you would like to ask me?

APPENDIX C

INDIVIDUAL INFORMED CONSENT

Project Title: Adolescents' Perceptions of Risk With Regard to Sexual Behavior

Alison Barnfather (MSc. Candidate) Centre for Health Promotion Studies University of Alberta Phone: 433-6387	Dr. Maryanne Doherty-Poirier (Supervisor) Department of Secondary Education Faculty of Education University of Alberta Phone: 492-3674

In this study Alison will ask me to talk about my sexual behavior and the sexual behaviors of young people my age. Alison is a master's student at the University of Alberta. What I tell her may help to improve health and sex education for teens.

The talk will take place in a private, quiet place that Alison and I both choose. The talk will be about one hour long. A second or third talk with Alison may be needed. The talk will be tape recorded and written out in notes. My name will not appear on any notes associated with the study or any publication resulting from this research. The notes will be private and will only be seen by Alison and those helping with her study. The information from the notes will be written up in a paper so that other people can read it. My real name will not be used. No one except Alison can match my name to what I say. My parents and friends will not be allowed to sit in the room when Alison and I talk and will not be able to listen to the tapes.

During the study this form will be kept locked up. The tapes and notes about the study will be locked in a separate place when not in use. Alison will tear up and throw away this form one year after the study is over. Alison will keep the notes and the tapes for seven years; then the notes will be torn up and the tapes will be erased. The information I give may be used to teach others and may be used in an article. What I say may be used in another study, if an ethics board approves the study.

I will not be paid nor get special care for being in the study. I understand that there will be no health risks to me resulting from my participation in the study. I know that the information from this study may help others. I can refuse to answer any question. I can quit any time I want just by talking to Alison. I will not be punished for quitting.

If I tell Alison anything that suggests that I may be in danger, Alison will talk to me about this. If I seem upset as a result of the questions asked, Alison may show me some information on where to get help or who to talk to for more information. Alison may ask a public health nurse or outreach worker to come see me if she's worried about my safety.

If I want to know about the results of this study, I will fill out the next page.

If I have questions, I can call Alison at 433-6387 or Maryanne Doherty-Poirier at 492-3674. I have a copy of this form.

I,_______________________(please print) agree to be in the study by Alison Barnfather.

Signature:_______________________________________

Researcher's Signature:______________________________

Date:_________________

Study Results

If you want to receive information about the results of this study, please fill out this form and return it to Alison Barnfather.

Please Print.

Name ______________________________

Address ____________________________

____

____

Note: Include postal code.

APPENDIX D

PARENTAL INFORMED CONSENT

Project Title: Adolescents' Perceptions of Risk With Regard to Sexual Behavior

Alison Barnfather (MSc. Candidate)
Centre for Health Promotion Studies
University of Alberta
Phone: 433-6387

Dr. Maryanne Doherty-Poirier (Supervisor)
Department of Secondary Education
Faculty of Education
University of Alberta
Phone: 492-3674

Dear "Parent":

Thank you for taking the time and interest to read this letter. My name is Alison Barnfather and I am a masters' student with the University of Alberta's Centre for Health Promotion Studies. I am conducting a research study designed to explore how young people view their risks with regards to sexual health. Perception of risk is a very important topic, especially in light of HIV/AIDS, sexually transmitted diseases, and teen pregnancy rates. Although many surveys have been done with the adolescent population of Canada, very little information has been collected from the adolescent's perspective. The information that I collect could be used to improve sexuality education in the schools. In order to develop better education for our young people, it is important that we allow them a "voice" rather than give them information which we "think they need." I have contacted your daughter/son and asked her/him to participate in a discussion with me.

Participation in the study is voluntary and your daughter/son will be free to withdraw without penalty at any point throughout the process of the study. If you agree to allow your teen to participate it will require up to three one-on-one interviews in which we will spend up to one hour talking about the sexual behaviors and sexual knowledge of young people their age. The interview will occur in a quiet, private place that we both choose. At no time will he/she have to identify him/herself to others by name, and he/she is free to not answer any question he/she does not want to.

All the interviews will be taped and transcribed; however, all the information provided will be kept strictly anonymous and confidential. No one except me will know your daughter/son has responded to the questions. Our interviews will be tape-recorded and these will be transcribed without anyone's name on the report. Your son/daughter's name will not appear on any notes or publications resulting from this study. If necessary a code number or pseudonym will be used to replace your son/daughter's name.

This letter is to seek your permission to allow your daughter/son to participate in this study. I personally guarantee the privacy of your daughter/son and that her/his name will not appear in any part of the study. Please feel free to call me at home at 433-6387 if you have any questions or concerns. I am working with Dr. Maryanne Doherty-Poirier in the

Department of Secondary Education, and you may contact her at 492-3674. I will be contacting your teen to confirm her/his involvement.

Please find enclosed consent forms that need to be signed before your daughter/son can participate in the study. Again, do not hesitate to call me if you have any questions.

Thank you very much.

Sincerely,

Alison Barnfather, BSc.

I give permission for my child ______________________ to participate in the study described in this letter by Alison Barnfather.

I DO NOT give permission for my child ____________________ to participate in the study described in this letter by Alison Barnfather.

Parent Signature ___________________________ Date _________________

If you wish to receive a copy of the summary of this study, please fill out the bottom half of this page and return to me with your consent form.

I would like to receive a copy of the summary.

Name: ______________________________

Address: ______________________________

____

____

Note: Please include postal code.

APPENDIX E

SUMMARY OF PARTICIPANT CHARACTERISTICS

Demographic Data: Pre-Interview Questions

Participant	Question 1	2	3	4	5	6	7	8
1	Female	Sep-80	Grade 11	Average mark: 78%	University	medicine	Job: Yes	Busgirl
2	Male	Nov-79	Not currently attending school		College	Military: Infantry	Job: Yes	Assistant Caretaker: at the Boys' &Girls Club
3	Female	Sep-79	Yes but in and out		College	hair dresser	Job: No	XXX
4	Female	Apr-81	Not currently attending school		College	cosmetology	Job: Yes	Office Assistant
5	Male	Oct-79	Not currently attending school		XXX	Get Job/Get Money	Job: Yes	Warehouse, Parking Company
6	Male	May-82	Not currently attending school		College	computer programming	Job: No	XXX
7	Male	May-81	Not currently attending school		Diploma	cook/baker	Job: Yes	General labourer
8	Male	May-82	Not currently attending school		Diploma	instrument mechanic Musical instruments	Job: Yes	Assistant Caretaker at the Boys' & Girls' Club
9	Female	Feb-81	Yes but in and out		University	computer animation	Job:Yes	Waitress
10	Male	Jan-82	Not currently attending school		Grade 10	labour work	Job: No	XXX
11	Female	Jul-81	Not currently attending school		Diploma	sign language interpreter	Job: No	XXX
12	Male	May-83	Currently in grade 10		University	computers	Job:Yes	Busboy

9	10	11	12	13
8hrs/week	lives with mom,stepdad, younger brother	mother born: Saskatchewan biological father born: B.C	Mother: nurse Stepfather: engineer	good communication all around
30-70hrs/week	lives with: roomate	mother born: Nova-Scotia father born: New Brunswick	Mother: disabled Father: truck driver	*** no contact with brother in 5yrs
XXX	lives with 3yr old daugther	mother born: Ontario father born: Ontario	mother: systems analyst father: cook	good relations all around
30 hrs/week	lives independently	mother born: B.C. father born: no idea	mother: dog groomer father: no idea	good understanding of each others' needs of time and space
8 hrs/week	lives independently	XXX	mother: counsellor	O.k.
XXX	lives independently	mother: Thunder Bay, Ontario	father: owns a recycling company	no comment
as needed	lives independently	mother: New Brunswick father: portugal	mother: auditor father: paper company	no relationship with family
40 hrs/week	lives in a support home	mother: Sudbury, Ontario father: Port au Port, N. F.	mother: housewife	healthy relationship with mother and sister: father has died
8 hrs/ week	lives independently	mother: Vietnam	XXX	not good with father,but OK with everyone else (4 sisters/1brother)
XXX	lives independently	XXX	mother: farmers market step-father: construction	not good at all, kicked out when 14 sister ok, 2 brothers not at all
XXX	lives independently	mother: Edmonton father: Edmonton	mother: nothing father: school	good relationship with the family
16 hrs/week	lives with parents, 2 brothers	mother: Trinidad father: Guyana, SA	mother: physical therapist father: information technical consultant	good relationship, mild problems with older brother and father

13b	14	15	16	17
go out with boyfriend, study movies,skating,dinner,climbing	Smoking: No	Alcohol: Yes once every 2 weeks	Drugs: Yes tried marijuana 2x	Religious: Yes 7th Day Adventist
dance, physical fitness, write	Smoking: Yes 3-7 per day	Alcohol: Yes 2x per week	Drugs: No	Religious: No
crafts, listen to music, watch tv visit with friends	Smoking: Yes 7-8 per day	Alcohol: Yes 2-3x per month	Drugs: No	Religious: Yes Christian Reform
go out with friends, dinner parties play cards, write poetry, sing	Smoking: Yes 8-12 per day	Alcohol: No * pregnant	Drugs: No	Religious: Yes Protestant
chill out, listen to music, watch tv	Smoking:Yes 17 per day	Alcohol: Yes lots on weekends	Drugs: No	Religious: Yes XXX
draw and listen to music	Smoking: Yes not sure	Alcohol: Yes once or twice a month	Drugs: No	Religious: Yes Lutheran
poetry, drawing, boxing, weights, any sports	Smoking: Yes 1 pack a day	Alcohol: Yes 1 per week	Drugs: Yes lots, often	Religious: No
play guitar and keyboard, writing, short stories&poety, time with girlfriend	Smoking: Yes 5 per day	Alcohol: No	Drugs: Yes mushrooms, pot, LSD once every 2 months	Religious: Yes Christian
listen to music, call friends, play sports	Smoking: No	Alcohol: No	Drugs: No	Religious: No
visit people, the mall, house parties	Smoking: Yes 15 per day	Alcohol: Yes not too much	Drugs: Yes weed,seed, ACID whenever I can afford it	Religious: No
go to mall, visit friends, read books do activities	Smoking: Yes 9 per day	Alcohol: Yes not very often	Drugs: No	Religious: No
work, go out, use the computer	Smoking: Yes 10 per day	Alcohol: Yes 2x per week	Drugs: Yes pot, magic mushrooms 2x week / 3x year	Religious: N/A looking for an appropriate religion

APPENDIX F

SUMMARY OF PARTICIPANT LIVING CONDITIONS

	Age at Independence	Living Situations	Reasons for Leaving
Kelly	16	family	pregnancy
Keith	14	family group home	kicked out
Karen	17	family	pregnancy
Kevin	12	family jail (2yrs) shelters streets	internal family conflict
Kurt	15	family father group home	internal family conflict
Kent	16	adoptive family group home	kicked out
Kelty	16	family mother	pregnancy
Katy	variable	mother and aunts	mother moved
Kyle	12	mother group home foster home friends hotel group home jail friends	internal family conflict

APPENDIX G

SUMMARY OF PARTICIPANT SEXUAL EXPERIENCES

Sexual Involvement of Adolescents

	Deep (French) Kissing	Above the Waist Petting	Below the Waist Petting	Oral Sex	Vaginal I/C (w/ out condom)	Vaginal I/C (w/ condom)	Anal I/C (w/out condom)	Anal I/C (w/ condom)
Ever	6x 7+ 1x 2-3	6x 7+ 1x 0	6x 7+ 1x 0	5x 7+ 1x 5 1x 0	4x 7+ 1x 2 1x 1 1x 0	3x 7+ 1x 2 3x 0	7x 0	1x 3 6x 0
Last 2 Months	6x 7+ 1x 0	4x 7+ 1x 4 1x 0	5x 7+ 1x 2 1x 0	4x 7+ 1x 3 1x 1 1x 4	4x 7+ 3x 0	2x 7+ 1x 1 4x 0	7x 0	7x 0